Provider Manual

aetna™

Last reviewed/revised: February 2021
For contract year July 1, 2020 – June 30, 2021

A note to providers:

This provider manual is to be used for the following Aetna Better Health of Virginia programs:

- Medallion 4.0 (including FAMIS)
- CCC Plus (Coordinated Care Plus)

Our D-SNP product, Aetna Better Health of Virginia HMO-SNP, utilizes a separate manual, which can be found at **AetnaBetterHealth.com/Virginia-hmosnp/providers/hmo-snp-pr/snp-manual**.

Provider Manual Attachments Section

This section of the Provider Manual contains the most commonly used documents, forms, and flyers providers use. For formulary information, please visit our pharmacy section. Simply select one of the below links, print it out, or create a bookmark on your computer for your future reference.

Provider Relations Information

- AetnaBetterHealth-VAProviderRelations@Aetna.com
- Quick Reference Guide

Quality Management Forms and Flyers

- CCC Plus Wellness Rewards Flyer
- Diabetes Wellness Exam Flyer
- Maternity Incentive Program Form
- Prenatal Risk Assessment Form Provider Incentive Flyer
- Ted E. Bear M.D. Incentive Flyer
- Well Woman Flyer

Claims, Appeals, and Additional Forms

- Authorization Release for Standard Appeal Form
- Electronic Funds Transfer (EFT) Enrollment/Change/Cancellation
- Electronic Remittance Advice (ERA) Enrollment/Change/Cancellation Form
- Prior Authorization Form
- Provider Dispute and Resubmission Form

Behavioral Health Forms

- ARTS Extension Service Authorization Request Form
- ARTS Initial Service Authorization Request Form
- ARTS Substance Use Case Management Registration Form
- Behavioral Therapy Initial Authorization Request Form
- CMHRS & Behavioral Therapy Continued Stay Service Authorization Request Form
- Day Treatment Partial Hospitalization (H0035 HB) Initial Service Authorization Request Form
- Intensive Community Treatment (H0039) Initial Service Authorization Request Form
- Intensive In-Home (H2012) Initial Service Authorization Request Form
- Mental Health Skill-Building (H0046) Initial Service Authorization Request Form
- Psychosocial Rehabilitation (H2017) Initial Service Authorization Request Form
- Service Registration Form
- Therapeutic Day Treatment (H0035-HA) Initial Service Authorization Request Form

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Chapter 1 — Welcome to Aetna Better Health

We are pleased that you are part of our network of providers. At Aetna Better Health, we are committed to providing accessible, high quality service to our members in Virginia, and we greatly appreciate all our providers' efforts in helping us achieve that goal.

To ensure we communicate effectively with providers, we have developed this Provider Manual. This document will help guide providers through our administrative processes. We will keep you up to date on any changes as they occur. These changes will be communicated to you in our provider newsletter, website, by letter or fax, and through regular contact with Provider Relations Representatives.

Thank you for your participation and interest in caring for our members.

About Aetna Better Health

For 30 years, Aetna Medicaid has honed our approach to serving high-acuity, medically frail, and low-income populations with diverse benefits. In Virginia, we have served the Medicaid population since 1996. Aetna Better Health of Virginia is a statewide Medicaid program offering managed care services and programs to individuals and families who qualify for:

Program	Population
Medallion	For low-income families and their children, pregnant women, and those in foster care or adoption assistance
FAMIS (Family Access to Medical Insurance Security)	For children of working parents who do not otherwise qualify for Medicaid
CCC Plus (Commonwealth Coordinated Care Plus)	For individuals with full Medicaid benefits who are 65 and older, children or adults with disabilities, nursing facility residents, or those receiving long-term services and supports.
D-SNP	A Medicare Special Needs Plan for individuals on Medicare and who receive Medicaid assistance

Our goal is to improve the functional status and quality of life for members, while providing budget predictability to our state partners. Our experience in implementing, managing, and caring for high-acuity Medicaid members results in improved access to care, higher quality care in appropriate settings, and a simplified consumer experience in a culturally competent manner. We take seriously our responsibility as a steward of public programs.

Today, Aetna Medicaid serves nearly three million members through Medicaid managed care plans In partnership with providers, community resources, and other key stakeholders, we offer an extensive suite of programs and services that work in concert to meet the individual needs of our most vulnerable members. While our programs and services continue to evolve and expand, our mission remains the same — building a healthier world by improving the lives and wellbeing of every member we are privileged to serve.

Model of care

Our model of care offers an integrated care management approach. The processes, oversight committees, provider collaboration, care management and coordination efforts applied to address

member needs result in a comprehensive and integrated plan of care for members. Aetna Better Health works to partner with providers to collaborate on managing member's care needs.

Many components of our integrated care management program influence member health. These include:

- Comprehensive member health assessment, clinical review, proactive discharge planning, transition management, and education directed towards obtaining preventive care. These care management elements are intended to reduce avoidable hospitalization and nursing facility placements/stays.
- Identification of individualized care needs and authorization of required home care services/assistive equipment when appropriate. This is intended to promote improved mobility and functional status and allow members to reside in the least restrictive environment possible.
- Assessments and care plans that identify a member's personal needs, which are used to direct education efforts that prevent medical complications and promote active involvement in personal health management.
- Care Management referral and predictive modeling software that identify members at increased risk, functional decline, hospitalization, and emergency department visits.

Our combined provider and care management activities are intended to improve quality of life, health status, and appropriate treatment. Specific goals of the programs include:

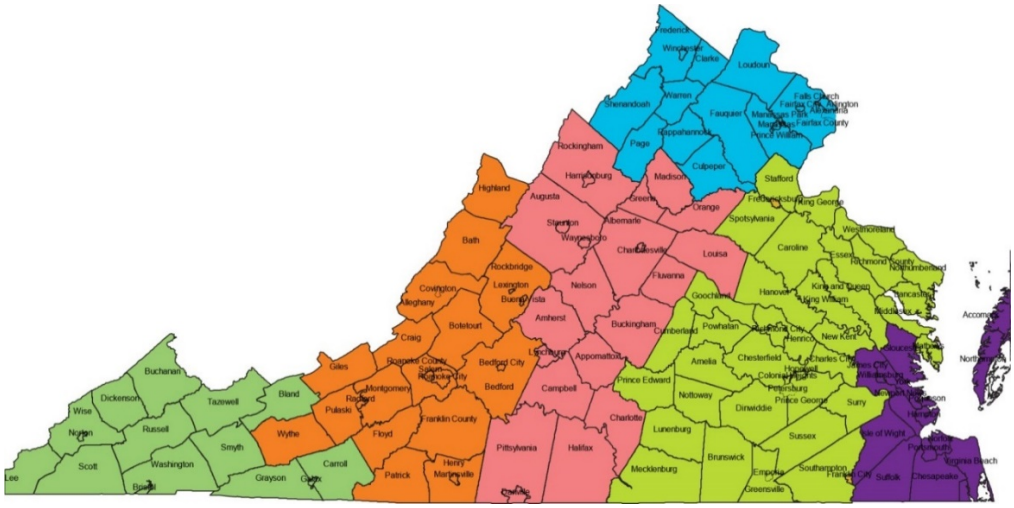
- Improving access to affordable care.
- Improving coordination of care through an identified point of contact.
- Improving seamless transitions of care across health care settings and providers.
- Promoting appropriate utilization of services and cost-effective service delivery.

Our efforts to promote cost-effective health service delivery include:

- Review of network for adequacy and resolve unmet network needs.
- Clinical reviews and proactive discharge planning activities.
- An integrated care management program that includes comprehensive assessments, transition management, and provision of information directed towards prevention of complications and preventive care services.

Service area

Our service area includes the entire Commonwealth of Virginia (all 95 counties and 38 independent cities) for Medallion 4.0 (including FAMIS) and CCC Plus.



Counties

Accomack
Albemarle
Alleghany
Amelia
Amherst
Appomattox
Arlington
Augusta
Bath
Bedford
Bland
Botetourt
Brunswick
Buchanan
Buckingham
Campbell
Caroline
Carroll
Charles City
Charlotte
Chesterfield
Clarke
Craig
Culpeper
Cumberland
Dickenson
Dinwiddie
Essex
Fairfax
Fauquier
Floyd
Fluvanna
Franklin
Frederick
Giles
Gloucester
Goochland
Grayson
Greene
Greensville
Halifax
Hanover
Henrico
Henry
Highland
Isle of Wight
James City
King and Queen
King George
King William
Lancaster
Lee
Loudoun
Louisa
Lunenburg
Madison
Mathews
Mecklenburg
Middlesex
Montgomery
Nelson
New Kent
Northampton
Northumberland
Nottoway
Orange
Page
Patrick
Pittsylvania
Powhatan
Prince Edward
Prince George
Prince William
Pulaski
Rappahannock
Richmond
Roanoke
Rockbridge
Rockingham
Russell
Scott
Shenandoah
Smyth
Southampton
Spotsylvania
Stafford
Surry
Sussex
Tazewell
Warren
Washington
Westmoreland
Wise
Wythe
York

Cities

Alexandria
Bristol
Buena Vista
Charlottesville
Chesapeake
Colonial Heights
Covington
Danville
Emporia
Fairfax
Falls Church
Franklin
Fredericksburg
Galax
Hampton
Harrisonburg
Hopewell
Lexington
Lynchburg
Manassas
Manassas Park
Martinsville
Newport News
Norfolk
Norton
Petersburg
Poquoson
Portsmouth
Radford
Richmond
Roanoke
Salem
Staunton
Suffolk
Virginia Beach
Waynesboro
Williamsburg
Winchester

About this provider manual

This provider manual serves as a resource to providers and outlines operations for Aetna Better Health. Throughout the provider manual, providers should be able to identify information on the majority of issues that may affect working with Aetna Better Health. Questions, problems, or concerns that the provider manual does not fully address can be directed to the Provider Relations department. Important contact information can be found in **Chapter 2 — Contacts**. Additional information for providers and members is available online at **AetnaBetterHealth.com/Virginia**.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of Aetna Better Health's provider agreement, including requirements described in this manual, and all federal and state regulations governing the provider. While this manual contains basic information about Aetna Better Health and the Department of Medical Assistance Services (DMAS), providers are required to fully understand and apply DMAS requirements when administering covered services. Please refer to **www.dmas.virginia.gov** for further information on DMAS. You can also access the DMAS Provider Manual **here**.

Chapter 2 — Contacts

Our standard business hours are Monday through Friday from 8 a.m. to 5 p.m. EST. Our office is closed on these holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Important phone numbers

Aetna Better Health	Toll-free
Medallion and FAMIS	**800-279-1878 (TTY: 711)**
CCC Plus	**855-652-8249 (TTY: 711)**

Important fax numbers

Aetna Better Health	Fax
Member Services department	**866-207-8901**
Prior Authorizations for Medallion and FAMIS	**866-669-2454**
Prior Authorizations for CCC Plus	**855-661-1828**
Provider Relations department	**844-230-8829**
Behavioral Health Services	**844-230-8829**
Appeals	**866-669-2459**
Care Management/Disease Management	**866-261-0581**
Inpatient Authorizations	**877-817-3707**

Important addresses

Department	Address
Claims	Electronic: Change Healthcare (Emdeon) **www.office.emdeon.com/vendorfiles/AetnaVA.html** Electronic Payor ID: 128VA Paper: Aetna Better Health of Virginia ATTN: Claims department P.O. Box 63518 Phoenix, AZ 85082-3518
Reconsiderations	Aetna Better Health of Virginia Attn: Reconsiderations P.O. Box 63518 Phoenix, AZ 85082-3518
Appeals	Aetna Better Health of Virginia PO Box 81040 5801 Postal Road Cleveland, OH 44181

Websites

In addition to the telephone numbers and addresses above, participating providers may access the Aetna Better Health website 24 hours a day, seven days a week at **AetnaBetterHealth.com/Virginia/providers** for up-to-date information, forms, and other resources. Our provider newsletter can be accessed at **AetnaBetterHealth.com/Virginia/providers/provider-news.**

Within the website, a secure Provider Portal is maintained. The web portal can be accessed directly at **AetnaBetterHealth.com/Virginia/providers/portal**. The secure Provider Portal provides a platform for Aetna Better Health to communicate health care information directly to providers.

The health plan's eligibility and claims information can be accessed via the Provider Portal. Additional information regarding the website and secure web portal is available in the Provider Relations chapter.

Commonwealth of Virginia Medicaid Program

General information regarding the Virginia Medicaid Programs and DMAS can be found online at **www.dmas.virginia.gov**

Topics	For additional information
Provider Information	**www.dmas.virginia.gov** Toll Free: **800-772-9996**, **800-884-9730** or for Richmond and Surrounding Counties: **804-965-9732** or **804-965-9733**
Provider Bulletins	**www.virginiamedicaid.dmas.virginia.gov/wps/portal**
Provider Enrollment	**www.virginiamedicaid.dmas.virginia.gov** (to access the online enrollment system or to download a paper application) Phone: **888-829-5373** or **804-270-5105**
Virginia Medicaid Eligibility	**www.coverva.org** Phone: **855-242-8282** (TTY: **888-221-1590**)
Adult and Child Abuse & Neglect Hotline	Child Abuse: **www.dss.virginia.gov/family/cps/index.cgi** Phone: **800-552-7096** Adult abuse: **www.dss.virginia.gov/family/as/aps.cgi** Phone: **888-832-3858**

Reporting suspected fraud, waste, or abuse

Participating providers are required to report to Aetna Better Health and to the state of Virginia all cases of suspected fraud, waste, or abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud waste or abuse to Aetna Better Health in the following ways:

- Write us:
  Aetna Better Health of Virginia
  ATTN: Compliance department
  9881 Mayland Drive
  Richmond, VA 23233-1458
- Call Aetna Better Health's Fraud, Waste and Abuse toll-free number at **844-317-5825**
- Visit Aetna Better Health's website and complete the requested information: **AetnaBetterHealth.com/Virginia/fraud-abuse**

Chapter 3 — Provider Relations department

The Provider Relations department serves as a liaison between Aetna Better Health and the provider community. This department also supports network development and contracting with multiple functions, including the evaluation of the provider network and compliance with regulatory network capacity standards.

Provider Relations

Provider Relations assists providers by providing education and assistance regarding a variety of topics. Provider Relations will:

- Provide education to provider offices.
- Provide support on Medicaid policies and procedures.

- Clarify provider contract provisions.
- Educate provider on compliance in respond to member's complaint from grievance & appeals.
- Assist with demographic changes, terminations, and initiation of credentialing.
- Conduct member complaint investigation.
- Maintain the provider directory.
- Assist practices to obtain secure web portal or member care login information.
- Be a point of contact for provider concerns and claims issues.

Our Network Relations department is responsible for the ongoing education and training of Aetna Better Health's provider community. We maintain a strong commitment to meeting the needs of our providers. In order to accomplish this, a Network Relations Consultant is assigned to specific groups of participating providers. This process allows each office to become familiar with its representative and form a solid working relationship. Each provider representative has a thorough understanding of our health plan operations and is well versed in the managed care program.

A Provider Relations Representative will visit or phone provider offices periodically to ensure providers' experiences with us are seamless. Representatives meet routinely with office staff and providers and are available upon request. Provider news, electronic messages, and specialized mailings are sent to providers periodically that include updates to the provider manual, changes in policies or benefits, and general news or information of interest to our provider community. If you need help with determining who your Provider Relations Representative is, please contact our plan by emailing us at **AetnabetterhealthVAProviderRelations@aetna.com** or calling **800-279-1878** (Medallion 4.0 and FAMIS) or **855-652-8249** (CCC Plus).

Joining the network

Providers interested in joining the Aetna Better Health network should visit **AetnaBetterHealth.com/Virginia/providers/join-our-network** or contact Provider Relations for additional information regarding contracting and credentialing.

Provider orientation

We provide initial orientation for newly contracted providers after joining our network. In follow up to initial orientation, we provide a variety of forums for ongoing provider training and education, such as routine site visits, group or individualized training sessions on select topics (i.e., member benefits, Aetna Better Health website navigation), distribution of provider newsletters and bulletins containing updates and reminders, and online resources through our website at: **AetnaBetterHealth.com/Virginia**.

Chapter 4 — Provider responsibilities and important information

This section outlines general provider responsibilities. Additional responsibilities are included throughout this manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with the terms of the Virginia Medicaid program, provider contract, and requirements in this manual. Aetna Better Health may or may not specifically communicate such terms in forms other than the provider contract and this manual.

Providers must act lawfully in the scope of practice of treatment, management, and discussion of the medically necessary care and advising or advocating appropriate medical care with or on behalf of a member, including providing information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered including all relevant risk, benefits and consequences of non-treatment. Advice given to potential or enrolled members should always be given in the best interest of the member.

Commonwealth of Virginia Medicaid (DMAS) provider enrollment

Providers who provide services to Aetna Better Health members must be enrolled as a Medicaid provider at each practice location with the Commonwealth of Virginia and credentialed by Aetna Better Health before they can provide health care to our members. To access online enrollment information or to download a paper application for the Commonwealth of Virginia, please refer to the department's website at **www.virginiamedicaid.dmas.virginia.gov** or phone: **888-829-5373** or **804-270-5105.**

National Provider Identifier (NPI) number

The NPI number is a 10-digit number that is provider-specific assigned by the Centers for Medicare and Medicaid (CMS). For additional information, please visit the National Plan/Provider Enumeration System (NPPES) website at **nppes.cms.hhs.gov**

NPI numbers are required for claims submission to Aetna Better Health. The CMS 1500 and UB04 claim forms contain fields specifically for the NPI information. On the CMS 1500 form, the rendering provider's (box 31) NPI number is placed in the bottom half of the 24 J fields. The NPI for the billing provider in box 33 is placed in the 33A field.

Medallion and FAMIS access and availability standards

We utilize accessibility/availability standards based on requirements from the National Committee for Quality Assurance (NCQA), state and federal regulations. The Access Standards are communicated to providers and members by newsletter, the Aetna Better Health website, and as part of the Provider Manual. Federal law requires that participating providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the provider serves only Medicaid recipients, hours offered to Medicaid managed care members must be comparable to those for Medicaid fee-for-service members. Practitioners and providers that do not meet Aetna Better Health of Virginia's access standards are provided recommendations for improvements in order to meet the set standard.

Timely access		
Timely access standards for hours of operation for PCPs: • General appointment availability — 20 hours per week per practice location		
Provider type	**Appointment type**	**Availability standard**
PCP	Emergency	Immediately upon request
	Urgent care	Within 24 hours
	Routine	Within 30 calendar days
Behavioral Health	Non-life-threatening emergency	Within six hours
	Urgent care	Within 48 hours
	Initial visit routine care	Within 10 working days
Prenatal	First trimester	Seven calendar days
	Initial second trimester	Seven calendar days

	Third trimester and high risk	Three working days from date of referral or immediately, if an emergency exists

Notes:

- A PCP is defined as family practice, internal medicine, pediatric, and general practice providers as well as, nurse practitioners, obstetricians/gynecologists, pediatricians, and specialists who perform primary care functions.
- High volume specialists are determined by the Health Plan through annual high-volume specialist reports. OB/GYN providers and oncologists are considered mandatory high volume/high impact specialist providers and will be added to the annual high-volume specialist listing.
- When developing the network, Aetna Better Health considers the linguistic and cultural preferences of health plan membership. Member access to more than one PCP that is multilingual and culturally diverse is required for Medicaid.
- Selection of ancillary provider access as determined by the state.

When the provider is unavailable, arrangements must be made for another PCP to cover services.

Provider's must provide covered services to Virginia Medicaid members 24 hour per day, seven day per week and must meet Virginia state standards for timely access to care and services, based on the urgency of need for services.

CCC Plus access and availability standards

The tables below indicate appointment wait time standards for primary and specialty care; standards for acceptable wait time in the office when a member has arrived for a scheduled appointment, and acceptable after-hour appointment standards.

Provider type	Appointment type	Availability standard
All Provider Types	Emergency	Appointments for emergency services shall be made available **immediately** upon the Member's request.
	Urgent care	All urgent care and symptomatic office visits shall be available within no more than 24 hours of the Member's request; however, as quickly as the symptoms demand. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring care in an emergency room setting.
	Routine	Appointments for routine, primary care services shall be made within **30 calendar days** of the Member's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty calendar days, or for routine specialty services like dermatology, allergy care, etc.

Prenatal	First trimester	Fourteen calendar days of request
	Initial second trimester	Seven calendar days of request
	Third trimester	Within five business days of request.
	High-risk	Within three business days of identification of high risk or immediately if emergency exists.

Behavioral Health	
Standard UM Review (to include outpatient and CMHRS)	3 business days if all clinical information is available or up to 5 business days if additional clinical information is required or as expeditiously as the Member's condition requires.
Initial and Concurrent Inpatient	1 business day if all clinical information is available or up to 3 business days if additional clinical information is required or as expeditiously as the Member's condition requires.
Expedited Urgent — Pre-service Inpatient	3 hours
Expedited Urgent reviews for other urgent services	24 hours

Providers must be available to members 24 hours a day, seven days a week. When the provider is unavailable, arrangements must be made for another PCP to cover services.

Providers must offer hours of operation to members of Aetna's Virginia Medicaid managed care program that are no less (in number or scope) than the hours of operation offered to other non-Medicaid patients, or if a provider serves only Medicaid members, hours of operation comparable to the hours of operation offered to members of the Commonwealth of Virginia's Medicaid Fee-for-Service Program. Provider agrees to provide covered services to Virginia Medicaid members on a 24 hour per day, seven day per week basis. Further, provider agrees to meet Virginia state standards for timely access to care and services, considering the urgency of need for services.

Monitoring of standards

Monitoring of network provider access and availability will be completed to ensure that the sufficiency of its network will meet the health care needs of members for PCPs, specialists, and CCC Plus providers, as needed. To monitor compliance with the access and availability standards, the health plan will:

- Review at least annually results of the Geo-access reports, completed by utilizing industry-standard software, to monitor compliance with the availability standards.
- Review the annual results of the Consumer Assessment of Health Plans Study, a member satisfaction survey, to monitor compliance with the accessibility and availability standards.
- Routinely monitor member complaints.
- Routinely monitor afterhours telephone accessibility and availability through member complaints and member and/or provider surveys or afterhours phone audits to ensure the provider or an associate is available 24 hours a day, seven days a week.
- Conduct announced and ad-hoc site visits to the providers office by Provider Relations representatives for any practices identified as meeting the threshold for member complaints.

Resolution of deficiencies

- In the event a participating network provider fails to meet provider access standards, the Provider Relations Representative will contact the provider to inform them of the deficiency, educate the standards to the provider, and work to correct the barrier to care.
- If there is a serious breach of the participating network providers' commitment to members and noncompliance with access to care, providers may be required to submit a Corrective Action Plan (CAP) and will be monitored until the CAP enables them to be compliant.
- If any network deficiencies are identified through the quarterly Geo-access review, applications or requests for participation will be sent to non-contracted facilities or providers in the affected service area(s).
- The health plan will also monitor and trend any member complaints regarding accessibility and availability of providers by product. If trends are identified, the health plan will promptly begin the recruiting process.

Covering providers

Aetna Better Health must be notified of practitioners who serve as covering providers for any of our network providers. This notification must occur in advance of the provision of any authorized services. Reimbursement to a covering provider is based on Virginia Medicaid fee schedule and dependent on enrollment as a provider with both Aetna Better Health and the state of Virginia Medicaid program. Failure to notify Provider Relations of covering providers may result in claim denials.

Verifying member eligibility

Regardless of contract status, all providers must verify a member's enrollment status prior to the delivery of nonemergent covered services. Providers are not reimbursed for services rendered to members who lost eligibility. Member eligibility can be verified through one of the following ways:

- Aetna Better Health's Secure Web Portal: **AetnaBetterHealth.com/Virginia/providers/portal**
- Aetna Better Health Member Services: **800-279-1878** (Medallion and FAMIS) or **855-652-8249** (CCC Plus).

The Commonwealth of Virginia Medicaid Eligibility Line is **855-242-8282**, and it will also have helpful information regarding the member's assigned managed care company and program eligibility.

Secure Provider Portal

The secure Provider Portal is a web-based platform that allows us to communicate member health care information directly with providers and in real time. Providers can perform many functions within this web-based platform. The following information can be attained from the secure Provider Portal:

- Member Eligibility Search — Verify current eligibility of one or more members
- Member ID Card — View a full version of the member ID card (front and back)
- Panel Roster — View the list of members currently assigned to the provider as the PCP
- Provider List — Search for a specific provider by name, specialty, or location
- Claims Status Search — Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
    - **Note to providers**: Claims cannot be billed through the provider portal. Change Healthcare has a secure portal for free electronic claim submissions at **www.changehealthcare.com**.

- Remittance Advice Search — Search for provider claim payment information by check number, provider, claim number, or check issue/service dates. Only remits associated with the user's account provider ID will be displayed.
- Provider Prior Authorization Lookup Tool — Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed. The tool will also allow providers to:
    - Search prior authorization requirements by individual or multiple CPT/HCPCS codes simultaneously.
    - Review prior authorization requirement by specific procedures or service groups.
    - Receive immediate details as to whether the codes are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information.
    - Export CPT/HCPS code results and information to Microsoft Excel.
    - Ensure staff works from the most up-to-date information on current prior authorization requirements.
- Submit Authorizations — Submit an authorization request online. Three types of authorization types are available:
    1. Medical Inpatient
    2. Outpatient
    3. Durable Medical Equipment (DME) — Rental

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website.

If you're interested in using this secure online tool, you can register at **AetnaBetterHealth.com/Virginia/providers/portal**, or you can also contact Provider Relations to sign up over the phone. To submit your registration via fax, you can download the form from our website or request a copy from Provider Relations. Please note that internet access and a valid email is required for registration.

Note: Provider groups must first register a principal user known as the "Provider Admin." Once registered, the "Provider Admin" can add authorized users within each entity or practice. For instructions to add authorized users, go to **AetnaBetterHealth.com/Virginia** and select *Provider Portal Instructions*.

Overview of features for members

Members can register for their own secure member portal accounts at **AetnaBetterHealth.com/Virginia/login**.

We have customized the member portal to meet their needs better. Members will have access to:

- Health and Wellness Appraisal — This tool will allow members to self-report and track their healthy behaviors and overall physical and behavioral health. The results will provide a summary of the members overall risk and protective factors and allow the comparison of current results to previous results, if applicable. The health assessment can be completed annually and will be accessible in electronic and print formats.
- Educational resources and programs — Members are able to access self-management tools for specific topics such as smoking cessation and weight management.
- Claim status — Members and their providers can follow a claim from the beginning to the end, including current stage in the process, amount approved, paid, member cost (if applicable) and the date paid.

- Pharmacy benefit services — Members can find out if they have any financial responsibility for a drug, learn how to request an exception for a noncovered drug, request a refill for mail-order medications, and find an in-network pharmacy by zip code. They can also find information on drug interactions, side effects and risk for medications and get the generic substitute for a drug.
- Personalized health plan services information — Members can now view and request a member ID card, change PCPs, and update their address through the web portal (address update is a feature available for members and providers). Members can also obtain referral and information on authorization requirements and they can find benefit and financial responsibility information for a specific service.
- Innovative services information — Members will be asked to complete a personal health record and complete an enrollment screening to see if they qualify for any disease management or wellness programs.
- Informed Health Line — The Informed Health Line is available 24 hours a day, seven days a week. Members can call or send a secure message to a registered nurse who can provide medical information and advice. Messages are responded to within 24 hours.
- Wellness and prevention information — We encourage healthy living. Our member outreach will continue to include reminders for needed care and missed services, sharing information about evidence-based care guidelines, diagnostic and treatment options, community-based resources, and automated outreach efforts with references to web-based self-management tools.

We encourage you to promote the use of the member portal during interactions with your patients. Members can sign up online at **AetnaBetterHealth.com/Virginia/login**, or they can call Member Services at **800-279-1878** (Medallion and FAMIS) or **855-652-8249** (CCC Plus).

Educating members

The federal Patient Self-determination Act gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Aetna Better Health shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Virginia Medicaid member who is his or her patient:

- For the Virginia Medicaid member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- For any information, the Virginia Medicaid member needs in order to decide among all relevant treatment options.
- For the risks, benefits, and consequences of treatment or non-treatment.
- For the Virginia Medicaid member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Aetna Better Health shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. Additionally, each managed care member is guaranteed the right to request and receive a copy of his medical records, and to request that they be amended or corrected as specified in *45 CFR Part 164*.

PCPs

PCPs are defined as providers who specialize in:

- Family practice, general practice, internal medicine, pediatrics, or obstetrics/gynecology.

- Certified nurse practitioners (CNP under direct supervision of a provider).
- Certified nurse midwife (under the supervision of a provider).

The PCP's role is to:

- Manage and coordinate the overall health care of members.
- Make appropriate referrals to participating providers.
- Obtain prior authorization for any referrals to nonparticipating providers.
- Provide or arrange for on-call coverage 24 hours/day, seven days a week.
- Accept new members, unless Aetna Better Health has been provided with written notice of a closed panel.
- Maintain comprehensive and legible medical records.

Specialist providers

The specialist's role is to:

- Agree to discuss treatment of members with the PCP.
- Render or arrange any continuing treatment, including hospitalization, which is beyond the specific treatment authorized by the PCP.
- Communicate any assessments or recommended treatment plans to the PCP.
- Obtain prior authorization for specified non-emergent inpatient and specified outpatient covered services.
- Maintain comprehensive and legible medical records.

Specialist providers acting as PCP

In limited situations, a member may select a provider specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. Specialists who perform primary care functions within certain provider classes, care settings, or facilities include but are not limited to federally qualified health centers, rural health clinics, health departments, and other similar community clinics or other providers.

Emergency services

Authorizations are not required for emergency services. In an emergency, please advise the member to call **911** immediately or go to the nearest emergency department. If a provider is not able to provide services to a member who needs emergent care, or if they call after hours, the member should be referred to the closest emergency department and to call **911** if necessary.

Urgent care services

Providers serve the medical needs of our members and are required to adhere to all appointment availability standards. In some cases, it may be necessary to refer members to a network urgent care center (after hours in most cases). Please reference the online directory on the Aetna Better Health website at **AetnaBetterHealth.com/Virginia/find-provider** and type in "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in the network.

Periodically, Aetna Better Health will review unusual urgent care and emergency room utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Medical home

The National Center for Medical Home Implementation defines a medical home as a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion, acute illness care, and chronic condition management. Performance/care coordination requirements of a medical home include the ability to:

- Provide comprehensive, coordinated health care for members and consistent, ongoing contact with members throughout their interactions with the health care system, including but not limited electronic contacts and ongoing care coordination and health maintenance tracking.
- Provide primary health care services for members and appropriate referral to other health care professionals or behavioral health professionals as needed.
- Focus on the ongoing prevention of illness and disease.
- Encourage active participation by a member and the member's family, guardian, or authorized representative, when appropriate, in health care decision making and care plan development.
- Facilitate the partnership between members, their personal provider, and when appropriate, the member's family.
- Encourage the use of specialty care services and supports.

Self-referral/direct access

Aetna Better Health has an open-access network, where members may self-refer, or directly access services without notice from their PCP. Aetna Better Health encourages all members to discuss specialty care with their PCP, who can coordinate needed services.

Services must be obtained from an in-network Aetna Better Health provider. There are exceptions to this, however; emergency, family planning, federally qualified and rural health centers, and tribal clinic services do not require prior authorization for in-network or out-of- network providers. Members may access these services from a qualified provider enrolled with the state of Virginia Medicaid program.

Second and third opinions

Aetna Better Health members have the right to a second opinion from a qualified health care professional any time the member wants to confirm a recommended treatment. A member may request a second opinion from a provider within our network. Providers should refer the member to another network provider within an applicable specialty for the second opinion. The member has a right to a third opinion when the recommendation of the second opinion fails to confirm the primary recommendation and there is a medical need for a specific treatment, and if the member desires the third opinion.

Aetna Better Health members will incur no expenses other than standard copays for a second and or third opinion provided by a participating provider, as applicable under the member Certificate of Coverage. Out-of-network services must receive prior authorization and are approved only when an in-network provider cannot perform the service.

Procedure for closing a PCP panel

A PCP who no longer wishes to accept new Aetna Better Health members may submit a written notification to Provider Relations to close his or her panel. In this situation, any new member who is not an established patient of that PCP cannot select that PCP's office with an approved closed panel.

A PCP may re-open a "closed" panel by submitting a written notification to Provider Relations. This change will be made on the first of the month following submission of the request, no less than thirty days from receipt of the written request. Additional time may be necessary to update printed marketing materials.

When an Aetna Better Health member chooses a PCP who has a "closed" panel, Member Services will notify the subscriber of the provider's panel status. If the provider chooses to make an exception to accept the member, they should contact Member Services for assistance in facilitating an over-ride to assign members to their practice on a case-by-case basis.

Noncompliant members/PCP transfer (termination)

Providers are responsible for delivering appropriate services to facilitate member understanding of their health care needs. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. Aetna Better Health will assist in the resolution of member specific compliance issues by providing comprehensive member education and care management protocols. Please contact Provider Relations for additional assistance in resolving member issues. They can be reached by email at **AetnaBetterHealth-VAProviderRelations@Aetna.com**.

If member non-compliance issues persist, additional steps can be taken to address these situations including transfer of the member from a provider practice. The DMAS Managed Care Program has a process in place for the PCP, as well as Aetna Better Health to request transfers of members to another PCP. The PCP or Health Plan may request that the member be transferred to another PCP based on the following or similar situations:

- The PCP has sufficient documentation to establish that the member/provider relationship is not mutually acceptable, e.g., the member is uncooperative, disruptive, does not follow medical treatment, does not keep appointments.
- Travel distance substantially limits the member's ability to follow through with the PCP services/referrals.
- The PCP has sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of the service by the member. (Note: Fraud and abuse investigation protocols are activated accordingly to investigate all identified potential cases).

The PCP and health plan must not request a transfer due to an adverse change in the member's health or adverse health status. The above reasons do not include a situation where a PCP has terminated a PCP-member relationship prior to managed care enrollment, unless the PCP can establish that the reason(s) for termination still remains an issue. The criteria for terminating a Medicaid member must not be more restrictive than the PCP's general office policy regarding terminations for non-Medicaid members.

Except in the case of death or illness, the provider agrees to notify the health plan at least 30 days in advance of disenrollment and agrees to continue care for his or her panel members for up to 30 days after such notification, until another PCP is chosen or assigned. It is recommended that your practice have an established policy for dismissing patients from the practice. Aetna Better Health members should be seen and treated in the same manner as other patients you see. Services or appointments cannot be refused in emergency or urgent care situations unless you have provided a member with at least 30 days' notice and requested that they select another provider. In the event of a member dismissal from your practice, the member should be notified in writing. It is recommended that the practice submit a copy to the health plan of the dismissal notification letter sent to the member. If requested, Aetna Better Health can assist the

member in selecting a new provider. This policy is to be used for special situations with specific patients only where just cause exists for dismissing the patient.

Medical records review

All participating PCPs, defined as family practice, general or internal medicine, OB/GYN and pediatrics, who provide medical care in ambulatory settings must comply with the health plan's medical record documentation standards. The following standards are required:

Medical Record Documentation	
1	Past medical history is completed (for members seen three or more times) and is easily identified. It includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
2	History and physical documents have subjective/objective information for presenting problem.
3	For members 14 years and older, there is appropriate notation about cigarettes, alcohol, and substance use. (For members seen three or more times, ask about substance abuse history.)
4	Note about follow-up care, calls, and visits. Specific time of return is noted in weeks, months or as needed.
5	An immunization record has been initiated for children and history for adults.
6	Preventive screenings and services are offered according to preventive services guidelines.
7	Prescribed medications are listed including dosages and dates of fill or refill.
8	Documentation about advance directives (whether executed or not) is in a prominent place in the member's record (except for under age 18).
9	Treatment plan current problem list is documented.
10	Working diagnoses are consistent with findings.
11	Evidence member is not at inappropriate risk relevant to particular treatment.
12	Blood pressure, weight, BMI percentile, and height measured/recorded at least annually, if member accesses care.
13	Lab and other studies are ordered, as appropriate.
14	Evidence that provider has reviewed lab, x-ray, or biopsy results (signed or initialed reports and the member has been notified of results before filing record).
15	Documentation of communications/contact with referred specialist and discharge summaries from hospitals.
16	Entries in patient records must be signed by the physician rendering the service (name and title) and dated (month, day, year) on the date of service delivery. Dates may not be typed onto medical records in advance of the signature. Care rendered under the supervision of the participating provider must be countersigned by that provider. See DMAS Physician/Practitioner Manual Chapter IV (Covered Services and Limitations). A signature log may be requested in the case of an audit of medical records.
17	The patient's name and ID number must be on each page. All entries are dated and legible.

The Quality Management department will audit PCP practices for compliance with the documentation standards. Written notification of aggregated review results is given to provider offices after the medical record audit has been completed.

The health plan will provide routine education to providers and their respective clinics. This may include but is not limited to, articles in our provider newsletter on the medical record review process, highlights of low compliance, adaptation of any universal forms by Aetna Better Health and updates of any changes

within the process and standards. Tools utilized to implement and maintain education may include emails, fax alerts, provider website, provider manual, and mailings.

Providers understand and agree that the health plan and its members shall not be required to reimburse them for expenses related to providing copies of patient records or documents to any local, state or federal agency (i) pursuant to a request from any local, state or federal agency (including, without limitation, CMS or such agencies' subcontractors; (ii) pursuant to administration of Quality Management, Utilization Review and Risk Management Programs, including the collection of HEDIS data; or (iii) in order to assist Aetna Better Health in making a determination regarding whether a service is a covered service for which payment is due hereunder.

All records, books, and papers of providers pertaining to members, including without limitation, records, books and papers relating to professional and ancillary care provided to members and financial, accounting, and administrative records, books and papers, shall be open for inspection and copying by Aetna Better Health, its designee and/or authorized state or federal authorities during provider's normal business hours. In addition, provider shall allow Aetna Better Health to audit provider's records for payment and claims review purposes. Provider further agrees to maintain all such members' records for services rendered for a period of time in compliance with state and federal laws.

Medical record audits

Aetna Better Health or DMAS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider administrative responsibilities, fraud, waste, or abuse or quality of care issues. Providers should respond to these requests promptly. Medical records must be made available to Aetna Better Health, DMAS, CMS, and federal or state authorities and their agents for quality review and/or audit upon request. Records must be stored in a secured HIPAA-compliant manner.

Access to facilities and records

Federal and local laws, rules, and regulations require that network providers retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health for inspection, evaluation, and audit for the longer of:

- A period of six years from the end of the contract with Aetna Better Health.
- The date the state of Virginia or their designees completes an audit.
- The period required under applicable laws, rules, and regulations.

Documenting member appointments and eligibility

When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at an office without an appointment), providers must verify eligibility and document the member's information in the medical record. Please access the Aetna Better Health website to electronically verify eligibility or call the Member Services department at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus).

Missed or cancelled appointments

Providers should:

- Document in the member's medical record and follow up on missed or canceled appointments.
- Conduct affirmative outreach to a member who misses an appointment by performing minimum reasonable efforts to contact the member.

- Notify Member Services when a member continually misses appointments.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA has many provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities, specifically providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit: **www.hhs.gov/ocr/hipaa**.
In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train office staff on HIPAA.
- Consider the location and handling of the patient sign-in sheet.
- Keep patient records, papers, and computer monitors out of view and in secure locations.
- Have electric shredder or locked shred bins available.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
  - The individual's past, present or future physical or mental health, or condition.
  - The provision of health care to the individual.
  - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, social security number).
  - Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health.
  - Release of data to third parties requires advance written approval from the member, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this Manual. For additional information, please visit: **www.aspe.hhs.gov/admnsimp/final/pvcguide1.htm**.

Member privacy rights

Aetna Better Health privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 CFR (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of PHI (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about Aetna Better Health practices regarding their PHI.
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI.
- Providing consistent review, disposition, and response to privacy requests within required time standards.
- Documenting requests and actions taken.

We are required by law to provide members with the *Notice of Privacy Practices*. This notice is included in the member's member packet and in our member newsletter. This notice informs members of their rights about the privacy of their personal information and how we may use and share personal information. Changes to this notice will apply to the information that we already have about the member as well as any information that we may receive or create in the future. Members may request a copy at any time by calling Member Services at **855-652-8249** or by visiting **AetnaBetterHealth.com/Virginia**.

In doctor offices, member's medical record will be labeled with their identification and stored in a safe location in the office where other people cannot it. If the doctor office uses a computer to store medical information, there should be a special password to safeguard member medical records.

Member medical record cannot be sent to anyone else without their written permission, unless required by law. When a member asks their doctor's office to transfer records, they will give the member a release form to sign. It's the doctor's office responsibility to do this service for our members.

We will assist the member:

- To provide quick transfer of records to other in or out-of-network providers for the medical management of their health
- When the member changes PCPs, to assure that their medical records or copies of medical records are made available to their new PCP.

If a member would like a copy of their medical or personal records, they may send us a written request. The member may also call Member Services at **855-652-8249** (TTY: **711**) and ask for a form that they or their representative can fill out and send back to us. Members have a right to review their requested medical records and ask they be changed or corrected.

Member privacy requests

Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint

- Receive a copy of all or part of the designated record set
- Request amendments/correction to records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communication.
- Receive a *Notice of Privacy Practices*

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health in writing.

Cultural competency

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, sexual preference, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health expects providers to treat all members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

Aetna Better Health has developed effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups and explain the relationship between cultural competency and health outcomes. These programs provide information on members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter, and we develop and implement proven methods for responding to those challenges. Additionally, as part of our cultural competency program, we encourage our providers to access information on the Office of Minority Health's web-based **A Physician's Guide to Culturally Competent Care**. The American Medical Association, American Academy of Family Physicians and the American College of Physicians endorse this program, which provides up to 9.0 hours of category 1 AMA credits at no cost. To access Aetna Better Health's Provider Cultural Competency training document, please visit **AetnaBetterHealth.com/Virginia/providers/provider-education/cultural**.

Health literacy — limited English proficiency (LEP) or reading skills

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and state requirements, Aetna Better Health is required to ensure members with LEP have meaningful access to health care services. Because of language differences and inability to speak or understand English, persons identified with LEP are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, gender identity, age, mental or physical disability, sexual orientation, sexual preference, genetic information or medical history, ability to pay or ability to speak English. Providers are required to treat all

members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with LEP or reading skills.
- Those with diverse cultural and ethnic backgrounds.
- The homeless.
- Individuals with physical and mental disabilities.

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and provider. However, if the provider chooses to use another resource for interpretation services other than those provided by the Health Plan, the provider is financially responsible for associated costs.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health Member Services.
- Representatives will assist the provider via a three-way call to communicate in the member's native language.
- For outgoing calls, Member Services dials the language interpretation service and uses an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health staff (e.g., Care Managers or Member Services) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health Member Services to link with an interpreter.

Aetna Better Health provides alternative methods of communication for members who are visually impaired, including large print and/or other formats. Alternative methods of communication are also available for hearing impaired members, which include accessing the state relay line (**711**). Contact our Member Services for more information on how to access alternative formats/services for visually or hearing impaired.

Aetna Better Health requires the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member. If interpreter services are declined, please document this in the members' medical record. This documentation could be important if a member decides that the interpreter he or she has chosen has not provided him/her with full knowledge regarding his/her medical history, treatment, or health education.

During the credentialing process for Aetna Better Health, we ask what other languages are spoken in the office so we may refer our members with special language needs.

Individuals with disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a provider's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to

provide appropriate accommodations such as large print materials and easily accessible doorways. Site visits will be conducted by our Provider Relations staff to ensure that network providers are compliant.

Receipt of federal funds, compliance with federal laws and prohibition on discrimination

Providers are subject to all laws applicable to recipients of federal funds, including, without limitation:

- Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 84.
- The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91.
- The Rehabilitation Act of 1973.
- The Americans With Disabilities Act.
- Federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law.
- The False Claims Act (31 U.S.C. §§ 3729 et. seq.).
- The anti-kickback statute (section 1128B(b) of the Social Security Act).
- HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

In addition, our network providers must comply with all applicable CMS laws, rules, and regulations, and network providers are prohibited from discriminating against any member on the basis of health status.

Providers shall provide covered services to members that are generally provided by a provider and for which the provider has been credentialed by Aetna Better Health. Such covered services shall be delivered in a prompt manner, consistent with professional, clinical, and ethical standards and in the same manner as to the provider's other patients. Provider shall accept members as new patients on the same basis as the provider accepts non-members as new patients. The provider shall not discriminate against a member on the basis of age, race, color, creed, religion, gender, gender identity, sexual preference, national origin, health status, use of covered services, income level, or on the basis, that member is enrolled in a managed care organization or is a Medicare or Medicaid member.

Out-of-network services

If Aetna Better Health is unable to provide necessary medical services covered under the contract within the network of contracted providers, Aetna Better Health will coordinate these services adequately and in a timely manner with out-of-network providers for as long as the organization is unable to provide the services. Aetna Better Health will provide any necessary information for the member to be able to arrange the service. The member will not incur any additional cost for seeking these services from an out-of-network provider.

Clinical practice guidelines

Aetna Better Health adopts evidence-based clinical practice guidelines (CPGs) for medical and behavioral health conditions from nationally recognized sources. Clinical practice guidelines and treatment protocols promote consistent application of evidence-based methodologies. We make the CPGs available to our network providers to help improve health care. We review CPGs at least every two years. We may review them more frequently if national guidelines change within the two-year period. These guidelines are not intended to:

- Supplant the duty of a qualified health professional to provide treatment based on the individual needs of the member.

- Constitute procedures for or the practice of medicine by the party distributing the guidelines.
- Guarantee coverage or payment for the type or level of care proposed or provided.

CPGs are available on our website at: **AetnaBetterHealth.com/Virginia/providers/guidelines.** For assistance in obtaining hard copies from the nationally recognized sources, contact your Provider Relations Representative. For Behavioral Health practice guidelines, Virginia adopted the American Psychiatric Association guidelines.

Financial liability for payment for services

In no event should a provider bill a member (or a person acting on behalf of a member) for payment of fees that are the legal obligation of Aetna Better Health. However, a network provider may collect deductibles, coinsurance, or copayments from members in accordance with the terms of the member's certificate of coverage or their member handbook. Providers must make certain they are:

- Agreeing not to hold members liable for payment of any fees that are the legal obligation of Aetna Better Health, and must indemnify the member for payment of any fees that are the legal obligation of Aetna Better Health for services furnished by providers that have been authorized by Aetna to service such members, as long as the member follows Aetna's rules for accessing services described in the approved member certificate of coverage and/or their member handbook.
- Agreeing not to bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Agreeing to clearly advise a member, prior to furnishing a noncovered service, of the member's responsibility to pay the full cost of the services.
- Agreeing that, when referring a member to another provider for a noncovered service, the provider must ensure the member is aware of his or her obligation to pay in full for noncovered services.

Health care acquired conditions (HCAC)

Procedures performed on the wrong side, wrong body part, wrong person, or wrong procedure are referred to in this policy as "wrong site/person/procedures," or WSPPs. CMS has adopted a national payment policy that all WSPP procedures are never reimbursed to facilities. CMS prohibits providers from passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse providers for WSPPs or for any WSPP-associated medical services. In addition, Aetna Better Health prohibits passing these charges on to patients.

HCACs are preventable conditions that are not present when patients are admitted to a hospital but become present during the course of the patient's stay. These preventable medical conditions were identified by CMS in response to the Deficit Reduction Act of 2005 and meet the following criteria:

1) The conditions are high-cost, high-volume, or both.
2) Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; could reasonably have been prevented through the application of evidence-based guidelines.

Effective **October 1, 2008**, CMS no longer issues payment for the extra care resulting from HCACs. CMS also prohibits passing these charges on to patients. Subject to CMS policy, Aetna Better Health will not reimburse hospitals for the extra care resulting from HCACs. In addition, Aetna Better Health prohibits passing these charges on to patients.

General reminders to all providers

- Obtain prior authorization from Aetna Better Health for all services requiring prior authorization.
- Referrals to nonparticipating providers, regardless of level of care must be preauthorized, unless specifically exempted from authorization, such as family planning and emergency services.
- Authorization approval does not guarantee authorized services are covered benefits.
- Benefits are always contingent upon member eligibility at the time of service.
- Understand that prior authorization is approved by Aetna Better Health based upon the present information that has been made available to the health plan. Payment for prior authorized covered services is subject to the compliance with Aetna Better Health's Utilization Management program, contractual limitations and exclusions, and coordination of benefits.
- Accept medical necessity and utilization review decisions; refer to the Grievance and Appeal Section of this provider manual if a provider disagrees with a review decision or claim that has been processed.
- Agree to collect only applicable copayments, coinsurance, and/or deductibles, if any, from members. Except for the collection of copayments, coinsurance, and/or deductibles, providers shall look only to Aetna Better Health for compensation for medically necessary covered services.
- Agree to meet credentialing and recredentialing requirements of Aetna Better Health.
- Providers must safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws and to maintain the member records in an accurate and timely manner.
- Providers shall provide covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care. Providers must render or order only medically appropriate services.
- Providers must obtain authorizations for all hospitalizations and confinements, as well as services specified in this manual and other provider communications as requiring prior authorization.
- Providers must comply fully with the terms of their agreement and maintain an acceptable professional image in the community.
- Providers must keep their licenses and certifications current and in good standing and cooperate with Aetna Better Health's recredentialing program. Aetna Better Health must be notified of any material change in the provider's qualifications affecting the continued accuracy of the credentialing information submitted to Aetna Better Health.
- Providers must obtain and maintain professional liability coverage as is deemed acceptable by Aetna Better Health through the credentialing/recredentialing process. Providers must furnish Aetna Better Health with evidence of coverage upon request and must provide the plan with at least thirty days' notice prior to the cancellation, loss, termination, or transfer of coverage.
- Providers shall ensure the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna Better Health including medical records data required and ensure the information is submitted on the applicable claim form.
- In the event the provider or Aetna Better Health seeks to terminate the agreement, it must be done in accordance with the contract.
- Providers must submit demographic or payment data changes at least sixty days prior to the effective date of change.
- Providers shall be available to Aetna Better Health members as outlined in the Access and Availability Standards section of this manual. Providers will also arrange 24-hour, on-call coverage for their patients by providers that participate with Aetna Better Health, as outlined within this manual.

- Providers must become familiar and to the extent necessary, comply with Aetna Better Health members' rights as outlined in the "Members Rights and Responsibilities" section of this manual.
- Participating providers agree to comply with Aetna Better Health's Provider Manual, quality improvement, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures and any other policies Aetna Better Health may implement, including amendments made to the mentioned policies, procedures, and programs from time to time.
- Providers will ensure they honor all Aetna Better Health members' rights, including, but not limited to treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care, and to actively participate in decisions regarding health and treatment options.
- Providers of all types may be held responsible for the cost of service(s) where prior authorization is required, but not obtained, or when place of service does not match authorization. The member shall not be billed for applicable service(s).
- Aetna Better Health encourages providers to contact Provider Relations at any time if they require further details on requirements for participation. They can be reached by email at **AetnaBetterHealth-VAProviderRelations@Aetna.com**.

Provider responsibilities to Aetna Better Health

Federal law and statutes (as outlined in the contract) are detailed below.

Civil rights, equal opportunity employment, and other laws

Provider shall comply with all applicable local, state and federal statutes and regulations regarding civil rights laws and equal opportunity employment, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. Provider recognizes that the Virginia Fair Employment Practice Act prohibits provider, in connection with its provision of services under this Amendment, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, or privileges of employment because of race, color, religion, sex, disability, or national origin. Provider guarantees its compliance with the Virginia Fair Employment Practice Act. Breach of this provision shall constitute a material breach of this Agreement.

Debarment and prohibited relationships

Provider acknowledges that Aetna Better Health is prohibited from contracting with parties listed on the non-procurements portion of the Commonwealth of Virginia's General Services Administration's "Lists of parties Excluded for Federal Procurement or Non-procurement Program." This list contains the names of parties debarred, suspended, or otherwise excluded by state agencies, and contractors declared ineligible under state statutory authority. Provider warrants that it is not on this list at the time of entering into this Amendment. Should provider's status with respect to this list change, provider agrees to notify Aetna Better Health immediately.

Provider acknowledges that Aetna Better Health may not contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. Provider warrants that it is not so excluded. Should provider's exclusion status change, Provider agrees to notify Aetna Better Health immediately. Further, provider shall not employ or contract for the provision of health care, utilization review, medical social work, or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

Provider acknowledges that Aetna Better Health is prohibited from maintaining a relationship with entities that have been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, and that Aetna Better Health is prohibited from having relationships with "affiliates" as the term is defined under the Federal Acquisition Regulation. Provider warrants that Aetna Better Health is not prohibited from maintaining a relationship with provider on these grounds, and provider agrees to notify Aetna Better Health immediately should its status change.

Federal sanctions

In order to comply with federal law (42 CFR 420.200 - 420.206 and 455.100 - 455.106), health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program. CMS requires Aetna Better Health and its subsidiaries to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid. The *Controlling Interest Worksheet* will be included with the credentialing application, as well as, the recredentialing application. This Form must be completed, signed, and dated when returned from the provider.

Medically necessary services

The term "medically necessary" refers to health care services that a physician provides to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. These services adhere to the following generally accepted standards of medical practice.

All services provided to Medicaid members must be medically necessary and reflect:

- Health care services and supplies which are medically appropriate.
- Necessary to meet the basic health needs of the member.
- Rendering delivery of the covered service in the most cost-efficient manner and setting appropriate.
- Consistent in type, frequency, and duration of treatment with evidence-based guidelines of national medical, research, or health care coverage organizations or government agencies.
- Consistent with the diagnosis of the condition,
- Provision of services required for means other than convenience of the member and/or his/her provider.
- Provision that is no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Provision of services of demonstrated value.
- Provision of services that is no more intense level of service than can be safely provided.

New technology

Emerging technologies are a daily occurrence in health care. Aetna Better Health has a Clinical Policy Research and Development team review new and emerging technology. We review new medical technologies and new technology applications regularly. We determine whether and how such technologies will be considered medically necessary and/or not experimental/investigational under our

benefits plans. The committee uses evidence-based clinical research to make determinations regarding the efficacy of the new technologies. Providers are advised of new technologies approved for coverage by Aetna's Clinical Policy Research and Development team via routine communications including the provider newsletter, bulletins, and ongoing Provider Relations contact.

Notice of provider termination

Aetna Better Health will make a good faith effort to give written notice of termination of a contracted provider, within thirty days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. It is the provider's responsibility to provide timely notification as indicated in the provider contract if they are requesting a termination from the network.

Health care reform update payments outside the United States

Effective **January 1, 2011**, Section 6505 of the Patient Protection and Affordable Care Act prohibits Medicaid health plans from making payments to financial institutions or entities located outside of the United States. This includes payments to providers, hospitals, and ancillary health care providers for items or services provided to Medicaid members through the Aetna Better Health contract with the state of Virginia. If you or your organization are located outside of the United States, or utilize a financial institution located outside of the United States, your payments will not be sent until you are located in the United States, or in the latter instance, establish a relationship with an entity located in the United States.

Provider responsibilities to members

This section outlines the provider responsibilities to Aetna Better Health members. This information is provided to providers to assist in understanding the requirements in place for the Medicaid program. Establishing an early PCP relationship is the key to ensuring that every Aetna Better Health member has access to necessary health care and to providing continuity and coordination of care. The member will already have chosen a PCP on the date their enrollment is effective. If necessary, Aetna Better Health will assign a PCP in the event that no selection is made.

PCP qualifications and responsibilities

To participate as a Virginia Managed Care Medicaid provider, the PCP must:

1. Be a Medicaid-enrolled provider and agree to comply with all pertinent Medicaid regulations.
2. Sign a contract with Aetna Better Health as a PCP which explains the PCP's responsibilities and compliance with the following Managed Care Medicaid requirements:
    a. Treat Managed Medicaid members in the same manner as other patients.
    b. Provide the Managed Medicaid member with a medical home including, when medically necessary, coordinate appropriate referrals to services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community based agency services.
    c. As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc..

d. Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours a day, seven days a week access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine that must immediately page an on-call medical professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours.
e. Not refuse an assignment or transfer a member or otherwise discriminate against a member solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except, for refusal of an assignment or transfer of a member, when that illness or condition can be better treated by another provider type.
f. Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the provider's office, e.g., TTD/TDD and language services, to accommodate the member's special needs.
g. Maintain a medical record for each member and comply with the requirement to coordinate the transfer of medical record information if the member selects another PCP.
h. Maintain a communication network providing necessary information to any MH/SA services provider as frequently as necessary based on the member's needs. Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services include but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans.
i. Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc..
j. Comply with all disease notification laws in the Commonwealth.
k. Provide information to the department as required.
l. Inform members about all treatment options, regardless of cost or whether such services are covered by the Virginia Medical Assistance Program

3. Provide accurate information to the Health Plan in a timely manner so that PCP information can be exchanged with DMAS and Aetna Better Health Provider Relations via the Provider Network File

Advanced directives

Aetna Better Health maintains written policies and procedures related to advance directives that describe the provision of health care when the member is incapacitated. These policies ensure the member's ability to make known his/her preferences about medical care before they are faced with a serious injury or illness.

Aetna Better Health's policy defines advance directives as a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (statutory or as recognized by the courts of the state) relating to the provisions of health care when the individual is incapacitated. The advance directive policy details our obligation for advance directives with respect to all adult individuals receiving medical care by or through the health plan. These obligations include, but are not limited to:

- Providing written information to all adult individuals concerning their rights under state law to make decisions concerning their medical care, accept or refuse medical or surgical treatment and formulate advance directives for health care.
- Documenting in a prominent part of the individual's medical record whether the individual has executed an advance directive.

- Not conditioning the provision of care or otherwise discriminating against an individual based on whether that individual has executed an advance directive.
- Ensuring compliance with requirements of state law concerning advance directives.
- Educating health plan staff and providers on advance directives.

Aetna Better Health's policies provide guidance on Aetna's obligations for ensuring the documentation of any advance directive decisions in the provider's member records, and monitoring provider compliance with advance directives including the right of the member to note any moral or religious beliefs that prohibit the member from making an advance directive.

Aetna Better Health will ensure that our providers are informed of their responsibilities in regard to advance directives. Our Provider Relations staff educates network providers on information related to advance directives through the Provider Contract, Provider Manual, Provider newsletters and during Provider Relations' onsite office visits. Aetna Better Health Network Management is responsible for:

- Ensuring provider contracts contain requirements that support members' opportunity to formulate advance directives.
- Ensuring the provider manual contains guidance on advance directives for Aetna Better Health members.

Aetna Better Health's Quality Management staff distributes medical record documentation standards annually to the providers. One of the medical record documentation standards requires that if a member has an executed advance directive, a copy must be placed in the member's medical record. If the member does not have an executed advance directive, the medical record would provide documentation that a discussion regarding advance directives has occurred between the provider and the member.

Aetna Better Health is committed to ensuring that adult members understand their rights to make informed decisions regarding their health care. Aetna Better Health's advance directives Medicaid Policy and Procedure provides guidance on our obligations for educating members and providers. Aetna Better Health educates providers on advance directives processes to ensure our members have the opportunity to designate advance directives.

At the time of enrollment, the health plan distributes written information to members on advance directives (including Virginia state law) through the member handbook. The information in the materials includes:

- Member's rights under state law, including a description of the applicable state law.
- Aetna Better Health's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- The member's right to file complaints regarding non-compliance with the state.

Aetna Better Health is responsible for educating members and providers about advance directives rights. The Compliance Officer is responsible for ensuring advance directives information appears, no less than annually, in our materials. Advance directives information is available in the:

- Member handbook.
- Member newsletter.
- Website.
- Provider manual.
- Provider newsletters.

Our Care Managers educate and offer advance directives information when appropriate. Additionally, providers are audited during on-site reviews to ensure policy and procedure compliance.

Chapter 5 — Credentialing and provider changes

Aetna Better Health's credentialing policy

Aetna's credentialing policy has adopted the highest industry standards, which are a combination of URAC/NCQA/CMS, plus applicable state and federal requirements. Exceptions to these standards are reviewed and approved based on local access issues determined by the local health plan. Aetna Better Health must follow and apply the provisions of state statutes, federal requirements, and accreditation standards that apply to credentialing activities.

Statement of confidentiality

Provider information obtained from any source during the credentialing/recredentialing process is considered confidential and used only for the purpose of determining the provider's eligibility to participate with in the Aetna Better Health network and to carry out the duties and obligations of Aetna Better Health operations, except as otherwise required by law.

Provider information is shared only with those persons or organizations who have authority to receive such information or who have a need to know in order to perform credentialing related functions. All credentialing records are stored in secured/locked cabinets and access to credentialing records is limited to authorized personnel only. Individual computer workstations are locked when employees leave their workstation. Access to electronic provider information is restricted to authorized personnel via sign-on security. All employees are trained and acknowledge training in accordance with federal HIPAA regulations. Disposal of all confidential documents must be via the locked confidential shred receptacles placed throughout the work area.

Credentialing/recredentialing

Aetna Better Health of Virginia uses current NCQA standards and guidelines for the review, credentialing and recredentialing of providers, with additional standards as required by the state of Virginia the majority of the process uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Professional providers and most other types of providers can use CAQH, whereas MLTSS non-traditional providers are credentialed and recredentialed through Aetna Medicaid's dedicated unit.

The Universal Credentialing Data Source was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing Data Source is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process.

All new providers (with the exception of hospital-based providers), including providers joining an existing participating practice with Aetna Better Health of Virginia, must complete the credentialing process and be approved by the Credentialing Committee.

Providers are recredentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required. Failure to complete the reappointment application and submit all of the required documents can cause providers to be terminated from the Aetna Better Health network. **Please note that while you are being credentialed, you will be listed as nonparticipating with Aetna Better Health of Virginia until your credentialing has been approved**.

Provider Credentialing

Aetna Better Health is committed to providing quality health care services to our members, and our credentialing processes help us achieve that goal.

To be eligible to join the Aetna Better Health of Virginia network, providers must have completed all required state licensure, and certification registration. The Letter of Interest (LOI) should be on the provider's letterhead or in writing.

Upon completion of the credentialing process, the provider will receive a copy of the executed contract along with a welcome packet from the Aetna Better Health of Virginia Network Contract Specialist with the effective date of participation.

What to Submit to Aetna Better Health Intake Team

- LOI
- Credentialing document
- Demographic changes
- Change of ownership or mergers
- Terminations (locations/providers)

The LOI/must include the following:

- Provider name
- Medicaid ID number
- License number (if applicable)
- Medicare ID number (if applicable)
- NPI
- Geographic location(s)
- Information outlining facility, specialty, and service offerings

The following are the general requests for a complete credentialing application submission and required documents:

- Complete facility application nontraditional provider application (if applicable)
    - Copy of State of Virginia License
    - Facility Credentialing Questionnaire
    - Accreditation (if applicable)
    - Current copy of professional liability insurance certificate
    - W9
    - Employment Qualification Attestation Form (if atypical and/or providing HCBS services)

- Complete Practitioner Credentialing Form
    - CAQH ID number
    - Authorize Aetna Better Health to access CAQH profile
    - Group roster (if applicable)
    - CAQH attestation updated within the last three months
- Upload required supporting documents to CAQH
    - Current Virginia medical license
    - Current Curriculum Vitae or resume
    - Proof of highest level of education
    - DEA license

- Board certificate(s) (if applicable)
- Current copy of professional liability insurance certificate
- W9

Credentialing approval date

Aetna Better Health of Virginia determines the credentialing approval date as the date the plan's medical director approves the credentialing documents received from the provider.

Network participation date

Aetna Better Health of Virginia uses the first day of the month following the credentialing approval date as the network participation date. Providers will receive notification of this date from the plan.

Recredentialing requirements

Aetna Better Health of Virginia uses current NCQA standards and guidelines for the review, credentialing and recredentialing of providers and uses CAQH ProView. CAQH ProView allows providers to submit one application to meet the needs of all the health plans and hospitals participating in the CAQH effort. To maintain the accuracy of the data, CAQH sends providers a reminder every 90 days to re-attest to their information.

Facility: Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as otherwise indicated.

Facility application (if applicable)

- Copy of state of Virginia license
- Facility Credentialing Questionnaire
- Accreditation (if applicable)
- Current copy of professional liability insurance certificate
- W9
- Employment Qualification Attestation Form (if typical and/or providing HCBS services)

Provider: Aetna Better Health of Virginia recredentials providers on a regular basis (every 36 months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (NCQA) requirements. Termination of the provider contract can occur if a provider misses the 36-month timeframe for recredentialing.

- CAQH must have been re attested within the last 90 days
- All required documents must be uploaded into CAQH
    - Current Virginia Medical license
    - Current Curriculum Vitae or resume
    - Proof of highest level of education
    - DEA license
    - Board certificate(s) (if applicable)
    - Current copy of professional liability insurance certificate
    - W9

What providers are not credentialed?

- Pathology

- Emergency Medicine
- Anesthesia
- Radiology
- Laboratory
- Physician assistants
- Assistants or technicians
- Locum tenens
- Provisionally licensed providers or providers without a fully unencumbered Virginia license

What providers do not require credentialing?

- Nurse practitioners employed by provider groups or by a medical facility
- Hospitalists
- Nurse anesthetists

Nurse practitioner recredentialing

- Nurse practitioners who have a solo practice

List of specialties credentialed

Facility

- Acute rehabilitation facility
- Acute short-term hospital
- Addiction facility, inpatient
- Addiction facility, intensive outpatient
- Addiction facility, outpatient
- Addiction facility, partial hospitalization
- Addiction facility, residential
- Behavioral health rehabilitation services
- Children's hospital
- Community mental health center
- Convalescent care facility
- Crisis stabilization program
- Diabetic treatment center
- Diagnostic laboratory
- Dialysis center
- Federally qualified health center
- Federally qualified health center - mental health
- Home health care agency
- Hospital
- Independent lab
- Inpatient psychiatric facility services
- Intensive outpatient program
- Internal medicine
- Internal medicine, hospice, and palliative care
- Interventional cardiology
- Long term acute care hospital
- Mental health facility, inpatient

- Mental health facility, intensive outpatient
- Mental health facility, outpatient
- Mental health facility, partial hospitalization
- Mental health facility, residential
- Nursing care agency
- Outpatient diabetics self-management training
- Outpatient physical therapy facility
- Outpatient speech pathology facility
- Partial day/hospitalization program
- Portable X-ray supplier
- Psychiatric hospital, acute and long term
- Residential treatment facility
- Rural health clinic
- Skilled nursing facility
- Substance abuse facility
- Voluntary interruption of pregnancy center

Atypical

- Adult day care
- Assisted living
- Case management
- Early intervention education
- Freestanding hospice
- Home delivered meals
- Home health care agency (non-skilled services only)
- Home infusion
- Home modification
- Homemaking
- Independent durable med equipment
- Infusion center
- Personal care
- Personal emergency response system
- Respite care
- Service facilitator

Provider

- Addiction medicine
- Addiction psychiatry
- Addictionology
- Adolescent and young adult medicine
- Adolescent medicine
- Adolescent medicine and pediatric
- Aerospace medicine
- Allergy/immunology
- Applied behavioral analysis
- Audiologist
- Cardiology

- Cardiovascular disease
- Child abuse
- Child psychiatry
- Clinical psychologist
- Clinical social worker
- Counselor
- Counselor, addiction
- Counselor, autism spectrum
- Counselor, child & adolescent
- Counselor, child & adolescent, addiction
- Counselor, child & adolescent, autism spectrum
- Counselor, child & adolescent, dialectical behavior therapy
- Counselor, child & adolescent, expressive therapy services
- Counselor, child & adolescent, family therapy
- Counselor, child & adolescent, home based services
- Counselor, child & adolescent, religious based services
- Counselor, child & adolescent, trauma/crisis
- Counselor, dialectical behavior therapy
- Counselor, expressive therapy services
- Counselor, family therapy
- Counselor, home based services
- Counselor, religious based services
- Counselor, trauma/crisis
- Critical care medicine
- Critical care medicine/anesthesiology
- Critical care medicine/neurological surgery
- Critical care medicine/obstetrics & gynecology
- Cytopathology
- Dermatology
- Dermatopathology/dermatology
- Dermatopathology/pathology
- Developmental behavioral pediatrics
- Drug and alcohol counselor
- Endocrinology
- Endocrinology, diabetes & metabolism
- Endocrinology, reproductive
- Endodontics
- Facial plastic surgery
- Family medicine, hospice, and palliative care
- Family practice
- Forensic psychiatry
- Gastroenterology
- General practice
- Geriatric medicine/internal medicine
- Gynecology
- Hematology

- Hematology/oncology
- Hematology/pathology
- Immunopathology
- In vivo and in vitro nuclear medicine
- Infectious disease
- Lactation consultant non-RN
- Licensed professional counselor
- Marriage/family therapist
- Massage therapist
- Maternal & fetal medicine
- Medical genetics
- Medical microbiology
- Medical toxicology
- Medical toxicology/preventive medicine
- Midwife
- Neonatal-perinatal medicine
- Neonatology
- Nephrology
- Neurodevelopmental disabilities
- Neurology
- Neurology & psychiatry
- Neurology, child
- Neurology/psychiatry, hospice, and palliative care
- Neuromuscular medicine physical medicine & rehab
- Neuromuscular medicine psychiatry & neurology
- Neuromusculoskeletal medicine
- Neuropathology
- Neuropsychologist
- Neuroradiology
- Neurotology
- Nuclear cardiology
- Nuclear medicine
- Obstetrics & gynecology
- Obstetrics/gynecology, hospice, and palliative care
- Occupational medicine
- Occupational therapist
- Occupational therapy
- Oncology
- Oncology, gynecologic
- Oncology, medical
- Oncology, orthopedic
- Ophthalmology
- Optometrist
- Oral surgeon
- Otolaryngology
- Otolaryngology (pediatrics)

- Otolaryngology/facial plastic surgery
- Otology
- Otology/neurotology
- Otorhinolaryngology
- Otorhinolaryngology/plastic surgery
- Pain management
- Pediatric allergy & immunology
- Pediatric ambulatory
- Pediatric anesthesiology
- Pediatric cardiology
- Pediatric critical care
- Pediatric dentistry
- Pediatric dermatology
- Pediatric emergency medicine
- Pediatric endocrinology
- Pediatric gastroenterology
- Pediatric hematology-oncology
- Pediatric infectious disease
- Pediatric intensive care
- Pediatric internal medicine
- Pediatric medical genetics
- Pediatric nephrology
- Pediatric neurology
- Pediatric ophthalmology
- Pediatric orthopedic
- Pediatric otolaryngology
- Pediatric pathology
- Pediatric physical medicine and rehabilitation
- Pediatric plastic surgery
- Pediatric pulmonology
- Pediatric radiology
- Pediatric rehabilitation medicine
- Pediatric rheumatology
- Pediatric sports medicine
- Pediatric surgery
- Pediatric thoracic & cardiovascular surgery
- Pediatric thoracic surgery
- Pediatric urology
- Pediatrics
- Pediatrics, hospice, and palliative care
- Perinatology
- Periodontics
- Physical medicine & rehabilitation
- Physical medicine, hospice, and palliative care
- Physical therapist
- Podiatrist

- Preventive medicine
- Preventive medicine/aerospace medicine
- Preventive medicine/occupational
- Preventive medicine/occupational therapy
- Preventive medicine/public health
- Proctology
- Psychiatric nurse
- Psychiatry
- Psychiatry, addiction
- Psychiatry, autism spectrum
- Psychiatry, child & adolescent
- Psychiatry, child & adolescent, addiction
- Psychiatry, child & adolescent, autism spectrum
- Psychiatry, child & adolescent, home based services
- Psychiatry, child & adolescent, religious based services
- Psychiatry, child & adolescent, trauma/crisis
- Psychiatry, geriatric
- Psychiatry, home based services
- Psychiatry, religious based services
- Psychiatry, trauma/crisis
- Psychological examiner
- Psychologist
- Psychologist, addiction
- Psychologist, autism spectrum
- Psychologist, child & adolescent
- Psychologist, child & adolescent, addiction
- Psychologist, child & adolescent, autism spectrum
- Psychologist, child & adolescent, expressive therapy services
- Psychologist, child & adolescent, family therapy
- Psychologist, child & adolescent, home based services
- Psychologist, child & adolescent, psychological testing
- Psychologist, child & adolescent, religious based services
- Psychologist, child & adolescent, trauma/crisis
- Psychologist, child & adolescent, dialectical behavior therapy
- Psychologist, dialectical behavior therapy
- Psychologist, expressive therapy services
- Psychologist, family therapy
- Psychologist, home based services
- Psychologist, psychological testing
- Psychologist, religious based services
- Psychologist, trauma/crisis
- Psychosomatic medicine
- Pulmonary disease
- Radiation oncology
- Registered dietician
- Registered nurse anesthetist

- Rehabilitation medicine
- Respiratory therapist
- Retinal ophthalmology
- Rheumatology
- Roentgenology
- Sleep medicine
- Sleep medicine - family practice
- Sleep medicine - neurology
- Sleep medicine - pediatric
- Sleep medicine-internal medicine
- Sleep medicine-ophthalmology/otolaryngology
- Spinal cord injury medicine
- Sports medicine
- Sports medicine/internal medicine
- Sports medicine/pediatrics
- Sports medicine/rehabilitation
- Surgery
- Surgery, colon & rectal
- Surgery, congenital cardiac/thoracic
- Surgery, general vascular
- Surgery, hand
- Surgery, hand/orthopedic
- Surgery, hand/plastic
- Surgery, head & neck
- Surgery, hospice, and palliative care
- Surgery, knee
- Surgery, neurological
- Surgery, obstetrics & gynecology
- Surgery, oncology
- Surgery, oral & maxillofacial
- Surgery, orthopedic
- Surgery, plastic
- Surgery, plastic and reconstructive
- Surgery, thoracic
- Surgery, thoracic cardiovascular
- Surgery, urological
- Surgical critical care
- Underseas medicine
- Urology
- Vascular neurology

If you have questions about the credentialing process or to check the status, please email Provider Relations at Aetnabetterhealth-VAProviderRelations@aetna.com.

Facility licensure and accreditation

Health care delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as otherwise indicated.

Ongoing monitoring

Ongoing monitoring consists of monitoring provider and or provider sanctions, or loss of license to help manage potential risk of substandard care to our members.

Additions or provider terminations

In order to meet contractual obligations and state and federal regulations, providers who are in good standing are required to report any terminations or additions to their agreement at least 90 days prior to the change in order for Aetna Better Health to comply with CMS and/or accreditation requirements. Providers are required to continue providing services to members throughout the termination period.

Providers are responsible to notify Provider Relations of any changes in professional staff at their offices (providers, provider assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact Provider Relations to discuss staff training, if needed.

State and accreditation guidelines require Aetna Better Health to make a good faith effort to provide written notice of a termination of a network provider at least thirty days before the termination effective date to all members who are patients seen on a regular basis by the provider whose contract is terminating. However, please note that all members who are patients of that PCP must be notified when a provider termination occurs.

Continuity of care

Providers terminating their contracts without cause are required to provide 60 days' notice (or otherwise determined by their contract) before terminating with Aetna Better Health. Provider must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Providers may also contact our Care Management department for assistance with continuity of care.

Non-discrimination

Aetna does not discriminate against any qualified applicant based on race, color, creed, ancestry, religion, age, disability, sex, national origin, citizenship, sexual orientation, disabled veteran, or types of procedures performed or types of patients the provider specializes, or Vietnam veteran status, in accordance with federal, state, and local laws.

All employees of Aetna Better Health are required to attend online training within 60 days of hire and annually thereafter, which requires passing a comprehensive quiz at the end of each training module. This training includes our Code of Business Conduct and Ethics, and Unlawful Harassment, both of which address our non-discrimination policies and practices.

Aetna maintains a compliance line **844-317-5825**, which is available 24 hours per day, seven days for all employees, as well as members and providers to call to report compliance matters. All Aetna Better Health employees have been educated on the compliance line and are encouraged to call if they suspect discrimination.

For any questions regarding the credentialing or recredentialing status of a provider, please contact Provider Relations.

Chapter 6 — Member benefits

Aetna Better Health believes that the essence of a successful Medicaid program is the extent that members understand their benefits and how to access them. We also go beyond simply educating members about covered services and put incentive programs in place to encourage benefit utilization.

Medallion 4.0 General Eligibility Information

- **Medallion 4.0 Medicaid** is for low-income and working individuals or families, their children, pregnant women, and those in foster care or adoption assistance. This includes adults who meet certain eligibility criteria under Medicaid Expansion.
- **Medallion 4.0 FAMIS (Family Access to Medical Insurance Security)** is for children under age 19 of working parents who do not otherwise qualify for Medicaid.

Medallion 4.0 General Coverage Rules

To receive coverage for services, members must meet the following general coverage requirements:

1. Services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means a member needs the services to prevent, diagnose, or treat a medical condition or prevent a condition from getting worse.
2. In most cases, a member must get care from a network provider. A network provider is a provider who works with Aetna Better Health. In most cases, Aetna Better Health will not pay for care a member gets from an out-of-network provider unless the service is authorized by Aetna Better Health.
3. Some benefits are covered only if a member's doctor or other network provider gets approval from Aetna Better Health first. This is called service authorization.
4. Aetna Better Health providers will file most claims for members. A member may have to file claims if care is received outside of the Aetna Better Health network.

Medallion 4.0 Copayments

Medallion

Aetna Better Health does not require copays for Medicaid members under the Medallion 4.0 program. Aetna Better Health will pay for all of their covered services. **There are no copayments, deductibles, or any other out of pocket costs for covered services.** Members should not sign or agree to pay for any services that are covered by the health plan. Providers should not balance bill members for covered services rendered. Members may be required to pay for services if they ask to receive services that are not covered by Aetna Better Health. If at any time Aetna Better Health submits requests to DMAS to allow for member copays, providers and members will be notified in advance of this change.

FAMIS

Most FAMIS members, which are part of the Medallion 4.0 program, have copayments (also called copays). Copays are a way for members to share in the cost of their care and are paid at the time of service to the provider. Some services, such as annual well check-ups and dental services, do not require

a copayment at all. **To determine the copays for FAMIS members, please refer to the member's ID card.**

Medallion 4.0 benefits covered through Aetna Better Health

Aetna Better Health covers the following services. Some services may require prior authorization:

- Regular medical care, including office visits with PCP, referrals to specialists, exams, etc.
- Preventive care, including regular check-ups, well baby/child exams
- Abortion services only in instances when there is or would be a substantial danger to life of the mother
- Addiction, recovery, and treatment services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services, and case management. Services may require authorization
- Behavioral health services, including inpatient and outpatient psychotherapy individual, family, and group are covered
- Clinic services
- Colorectal cancer screening
- Community Mental Health and Rehabilitative Services
- Court ordered services
- Durable medical equipment and supplies (DME)
- Early and periodic screening diagnostic and treatment services (EPSDT) for children under age 21
- Early intervention services designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third birthday
- Electroconvulsive therapy (ECT)
- Emergency custody orders (ECO)
- Emergency services including emergency transportation services (ambulance, etc.).
- Emergency and post stabilization services
- End stage renal disease services
- Eye examinations
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of Aetna Better Health's network. Aetna Better Health does not require members to obtain service authorization or PCP referrals on family planning services
- Glucose test strips
- Hearing (audiology) services
- Home health services
- Hospital care – inpatient/outpatient
- Human Immunodeficiency Virus (HIV) testing and treatment counseling
- Immunizations
- Inpatient psychiatric hospital services
- Laboratory, Radiology and Anesthesia Services
- Lead testing and investigations
- Mammograms
- Maternity care - includes pregnancy care, doctors/certified nurse-midwife services
- Nurse Midwife Services through a Certified Nurse Midwife provider
- Organ transplants

- Orthotics, including braces, splints and supports - for children under 21, or adults through an intensive rehabilitation program
- Outpatient hospital services
- Pap smears
- Physician's services or provider services, including doctor's office visits
- Physical, occupational, and speech therapies
- Podiatry services (foot care)
- Prenatal and maternal services
- Prescription drugs
- Private duty nursing services (through EPSDT) Under Age 21
- Prostate specific antigen (PSA) and digital rectal exams
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses)
- Psychiatric or psychological services
- Radiology services
- Reconstructive breast surgery
- Renal (kidney) dialysis services
- Rehabilitation services – inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services)
- Second opinion services from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs
- Surgery services when medically necessary and approved by Aetna Better Health
- Telemedicine services
- Temporary detention orders (TDO)
- Tobacco Cessation Services
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs. Aetna Better Health will also provide transportation to/from most carved-out services
- Vision services
- Well Visits

The covered services provided to Aetna Better Health members include all those listed above and the following additional services:

- Diagnosis and treatment for defects in hearing including hearing aids for members under 21 years of age
- Dental services medically needed because of an accidental injury when the member's doctor submits a plan of treatment to us within sixty days of the date of the member's injury and receives our preauthorization for the plan of treatment and the injury did not occur during the act of biting or chewing

Medallion 4.0 enhanced benefits and services

As a member of Aetna Better Health, our members have access to services that are not generally covered through Medicaid fee-for-service. These services are known as "enhanced benefits." We provide the following enhanced benefits:

- **Adult dental**: Two dental exams and cleanings and bitewing X-rays and fillings each year. Extractions covered in standard benefits.
- **Adult vision**: One eye exam and $100 for frames, glasses, or contacts each year.
- **Adult hearing**: One hearing exam and one hearing aid per year, unlimited visits for hearing aid
- fittings.
- **Non-emergent transportation:** Unlimited medical rides and rides to pharmacy within a 50-mile radius. 30 round trips or 60 one-way visits for non-emergent rides (annually) to grocery stores, food bank, food pantry, places of worship, DMV, library, and exercise classes or gym within a 50-mile radius
- **Asthma prevention**: Hypoallergenic bedding and carpet cleaning for members with asthma.
- **Better Breathing**: second inhaler/nebulizer for asthmatic school-age members to use at school.
- **Diabetes Care for Life**: A personalized and interactive mobile program available to members diagnosed with diabetes that sends text messages to inform enrollees regarding diabetes education and support; personal care management; appointment and medication reminders; and exercise/ weight goal setting and tracking.
- **Home-delivered meals**: After discharge from an inpatient stay, adult and child members can receive two meals a day tailored to their dietary needs and delivered to their home or community-based setting for up to seven days.
- **Weight management**: 12-week certified nutritionist program and six counseling visits.
- **No-cost cellphones**: Free smartphone with 350 talk minutes, data, unlimited text messages, and free calls to Member Services each month.
- **Expanded Member Services call center hours**: To assist members 24/7.
- **Maternity Incentive Program**: Baby Matters maternity incentive program ($50 gift card for pre- and postnatal check-ups), diapers for one month (300 diapers), free breast pump and lactation classes
- **Non-traditional medicine**: Some members, including those who are part of the federally recognized Tribal Nation in the Commonwealth wish to participate in non-traditional healing practices, as well as traditional practices. This benefit is designed to supported nontraditional practices for any interested member, and it requires no prior authorization.
- **General Educational Development (GED) incentive**: Support for members 16 years and older who are seeking their GED certificate. For members who meet state eligibility requirements, Aetna Better Health will pay for access to Covcell, an online GED training program that helps individuals pass the GED test by providing prep courses and guidance. Aetna Better Health will also pay for members GED testing voucher. Members can learn more about requirements by calling Member Services at **1-800-279-1878 (TTY: 711)**.
- **Swimming lessons**: Water safety and swimming lessons for members six and younger at their nearest YMCA location.
- **Smoking cessation**: Counseling and pharmaceuticals to assist members to stop smoking.
- **Ted E. Bear, M.D. ® Wellness Club**: All members, from newborns up to the age of 17, have a special friend in the Ted E. Bear M.D. Wellness Club, which allows participants to earn incentives for

completing their physical exam, shots (as needed), weight and nutrition counseling, and a growth and development check.
- **Youth Sport Physicals**: Annual sports participation physical offered to members 12 to 18 years of age.
- **No-cost cell phone:** Free smartphone with 350 minutes, 3 GB of data and unlimited texts monthly. Free calls to Aetna Better Health Member Services and virginiamanagedcare.com. Members can apply at AetnaBetterHealth.com/Virginia/Members/Phones
- **Wellness rewards**: Incentive gift card: $25 for wellness exam (to include BP check, HbA1c labs and diabetic eye exam), $15 for woman's mammography, $15 for cervical cancer screening.

Medallion 4.0 Services Not Covered

The following services are not covered by Medicaid or Aetna Better Health. If a member receives any of the following non-covered services, the member will be responsible for the cost of these services.

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Assisted suicide
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Christian science nurses
- Cosmetic treatment or surgery
- Dentures for members age 21 and over
- Drugs prescribed to treat hair loss or to bleach skin
- Elective abortions
- Erectile dysfunction drugs
- Experimental or Investigational Procedures
- Eyeglasses repair for members age 21 or older
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by Aetna Better Health)
- Medical care other than emergency services, urgent services, or family planning services, received from providers outside of the network unless authorized by Aetna Better Health
- Routine dental care if you are age 21 or older
- Services rendered while incarcerated
- Travel time
- Weight loss clinic programs unless authorized
- Care received outside of the United States and its territories

If a member receives non-covered services

If a member receives non-covered services, Aetna Better Health we will only cover the services when the member is enrolled with our plan and:

- Services are medically necessary
- Services are listed as covered benefits through Aetna Better Health
- Services are received by following plan rules

If a member receives services that are not covered by our plan or covered through DMAS, the member will be responsible for the full cost of the services received. Members have the right to ask Aetna Better Health if they are not sure and want to know if we will pay for any medical service or care. Members can call Member Services or their Care Manager to find out more about services and how to obtain them. Members also have the right to ask for this in writing. If we say we will not pay for a member's services, the member has the right to appeal our decision. Members may also call Member Services to learn more about their appeal rights or to obtain assistance in filing an appeal.

Medallion 4.0 Services Covered Through Medicaid Fee-For-Service

DMAS will provide members with coverage for any of the services listed below. These services are known as "carved-out services." The provider will need to bill DMAS or its Dental Benefit Administrator (DBA) for these services.

Carved-out services:

- Dental Services provided through the Smiles for Children program.
- DMAS has contracted with DentaQuest to coordinate the delivery of all Medicaid dental services. The name of the program is Smiles for Children. Smiles for Children provides coverage for the following populations and services:
    - For children under the age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services.
    - For pregnant women: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, bridges, partials, and dentures, tooth extractions, other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. Dental coverage ends on the last day of the month following the 60th day after the baby is born.
    - For adults age 21 and over, coverage is only available for limited medically necessary oral surgery services. Routine dental services are not covered for adults other than as described above for pregnant women.
    - If you have any questions about your dental coverage through Smiles for Children, you can reach DentaQuest Member Services at **1-888-912-3456**, Monday through Friday, 8 a.m. – 6 p.m. EST. The TTY number is **1-800-466-7566**. Additional Smiles for Children program information is available at: **www.coverva.org/programs_smiles.cfm**.
    - Aetna Better Health provides coverage for non-emergency transportation for any dental services covered through Smiles for Children, as described above. Contact Aetna Better Health Member Services at the number below if you need assistance.
    - School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.

Services that will end a member's Medallion 4.0 enrollment

If a member receives any of the services below, their enrollment with Aetna Better Health in our Medallion 4.0 program will close and the member will be served by the Medicaid Fee-For-Service program or the CCC Plus program so long as the member remains eligible for Medicaid:

- Care in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Care in a Psychiatric Residential Treatment Level C Facility (children under 21)
- Care in a nursing facility
- Care in a long-term care facility
- Hospice care

CCC Plus General Eligibility Information

CCC Plus is for individuals with Medicaid benefits, and meet one of the following categories:

- Age 65 and older,
- Adult or child with a disability,
- Resides in a nursing facility (NF),
- Receives services through the CCC Plus home and community based services waiver [formerly referred to as the Technology Assisted and Elderly or Disabled with Consumer Direction (EDCD) Waivers],
- Receives services through any of the three waivers serving people with developmental disabilities (Building Independence, Family & Individual Supports, and Community Living Waivers), also known as the DD Waivers.

CCC Plus General Coverage Rules

To receive coverage for services, members must meet the general coverage requirements described below.

1. Services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means you need the service or supplies to prevent, diagnose, or treat a medical condition or its symptoms based on accepted standards of medical practice.
2. In most cases, members must get care from a network provider. A network provider is a provider who works with Aetna Better Health. In most cases, Aetna Better Health will not pay for care a member gets from an out-of-network provider unless the service is authorized by Aetna Better Health.
3. Some member benefits are covered only if the member's doctor or other network provider gets approval from Aetna Better Health first. This is called a service authorization.
4. If Aetna Better Health is new for a member, the member can keep seeing the doctors they go to now during the 30 day continuity of care period. Members can also keep getting authorized services for the duration of the authorization or during the continuity of care period after the member first enrolls, whichever is sooner.

CCC Plus Copayments

There are no copayments for services covered through the CCC Plus program. This includes services

that are covered through Aetna Better Health or services that are carved-out of the CCC Plus contract. The services provided through Aetna Better Health or through DMAS will not require a member to pay any costs other than their patient pay towards long-term services and supports.

CCC Plus does not allow providers to charge members for covered services. Aetna Better Health pays providers directly. This is true even if we pay the provider less than the provider charges for a service.

If a member receives services that aren't covered by our plan or covered through DMAS, the member must pay the full cost. If a member is not certain wants to know if we will pay for any medical service or care, please have them contact Member Services.

Member Patient Pay Towards Long Term Services and Supports (LTSS)
Members may have a patient pay responsibility towards the cost of nursing facility care and home and community based waiver services. A patient pay is required to be calculated for all members who get nursing facility or home and community based waiver services. When a member's income exceeds a certain amount, the member must contribute toward the cost of LTSS. If the member has a patient pay amount, they will receive notice from their local Department of Social Services (DSS) for their patient pay responsibility. DMAS also shares their patient pay amount with Aetna Better Health if the member is required to pay towards the cost of LTSS. If a member has questions about their patient pay amount, they should contact their Medicaid eligibility worker at the local Department of Social Services.

Medicare Members and Part D Drugs
If a member has Medicare, they get their prescription medicines from Medicare Part D, not from the CCC Plus Medicaid program. CCC Plus does not pay the copayment for the medicines that Medicare Part D covers.

CCC Plus Benefits Covered Through Aetna Better Health

Aetna Better Health covers all of the following services for members. Some services may require prior authorization. If a member has Medicare or another insurance plan, we will coordinate these services with Medicare or other insurance plan.

- Regular medical care, including office visits with your PCP, referrals to specialists, exams, etc.
- Preventive care, including regular check-ups, screenings, and well-baby/child visits
- Addiction and Recovery Treatment Services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services, and case management. Services may require authorization
- Adult day health Care services (see CCC Plus Waiver)
- Behavioral health services, including, inpatient and outpatient individual, family, and group psychotherapy services, Community Mental Health Rehabilitation Services (CMHRS) including:
    - Mental Health Case Management
    - Therapeutic Day Treatment (TDT) for Children
    - Day Treatment/ Partial Hospitalization for Adults
    - Crisis Intervention and Stabilization
    - Intensive Community Treatment
    - Mental Health Skill-building Services (MHSS)
    - Intensive In-Home
    - Psychosocial Rehabilitation

    - Behavioral Therapy
    - Mental Health Peer Supports
- Care coordination services, including assistance connecting to CCC Plus covered services and to housing, food, and community resources
- Clinic services, including renal dialysis
- CCC Plus Home and Community Based Waiver services, (formerly known as the EDCD and Technology Assisted Waivers), including: adult day health care, assistive technology, environmental modifications, personal care services, personal emergency response systems (PERS), private duty nursing services, respite services, services facilitation, transition services
- Colorectal cancer screening
- Court ordered services
- Durable medical equipment (DME) and supplies including medically necessary respiratory, oxygen, and ventilator equipment and supplies, wheelchairs and accessories, hospital beds, diabetic equipment and supplies, incontinence products, assistive technology, communication devices, and rehabilitative equipment and devices and other necessary equipment and supplies
- Early and Periodic Screening Diagnostic and Treatment services (EPSDT) for children under age 21
- Early Intervention services for children from birth to age 3.
- Electroconvulsive therapy (ECT)
- Emergency custody orders (ECO)
- Emergency services including emergency transportation services (ambulance, etc.)
- Emergency and post stabilization services
- End stage renal disease services
- Eye examinations
- Family planning services, including services, devices, drugs (including long acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of Aetna Better Health's network. Aetna Better Health does not require members to obtain a service authorization or a PCP referral for family planning services
- Glucose test strips
- Hearing (audiology) services
- Home health services
- Hospice services
- Hospital care – inpatient/outpatient
- Human Immunodeficiency Virus (HIV) testing and treatment counseling
- Immunizations
- Inpatient psychiatric hospital services
- Laboratory, Radiology and Anesthesia Services
- Lead investigations
- Mammograms
- Maternity care - includes: pregnancy care, doctors/certified nurse-midwife services
- Nursing facility - includes skilled, specialized care, long stay hospital, and custodial care
- Nurse Midwife Services through a Certified Nurse Midwife provider
- Organ transplants
- Orthotics, including braces, splints and supports - for children under 21, or adults through an intensive rehabilitation program
- Outpatient hospital services

- Pap smears
- Personal care or personal assistance services (through EPSDT or through the CCC Plus Waiver)
- Physician's services or provider services, including doctor's office visits
- Physical, occupational, and speech therapies
- Podiatry services (foot care)
- Prenatal and maternal services
- Prescription drugs
- Private duty nursing services (through EPSDT and through the CCC Plus HCBS Waiver)
- Prostate specific antigen (PSA) and digital rectal exams
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses)
- Psychiatric or psychological services
- Radiology services
- Reconstructive breast surgery
- Renal (kidney) dialysis services
- Rehabilitation services – inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services)
- Second opinion services from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.
- Surgery services when medically necessary and approved by Aetna Better Health
- Telemedicine services
- Temporary detention orders (TDO)
- Tobacco Cessation Services for pregnant women, children, and adolescents under age 21
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs). Aetna Better Health will also provide transportation to/from most "carved-out" and enhanced services
- Vision services
- Well Visits
- Abortion services - coverage is only available in cases where there would be a substantial danger to the life of the mother

CCC Plus Enhanced Benefits and Services

Added Benefit	Services and Limits	Qualifying Members	Approval Criteria
Adult Dental Care	**DentaQuest** 844-824-2018 Exam and cleaning twice per year, annual set of bitewing X-rays, fillings, root canal or dentures (limited to $525 annually)	Age 21 and older	No prior authorization required

Added Benefit	Services and Limits	Qualifying Members	Approval Criteria
Adult Vision	**VSP (Vision Service Plan)** 800-877-7195 Exam and $100 toward eyewear per year	Age 21 and older	No prior authorization required
Adult Hearing	**Hear USA** 855-802-5529 Exam and one hearing aid per year, plus unlimited visits for hearing aid fittings (Limited to $500 annually)	Age 21 and older	Requires prior authorization
Non-Emergent Transportation	**LogistiCare** 800-734-0430 Unlimited medical rides and rides to pharmacy within a 50-mile radius. 30 round trips or 60 one-way trips for non-emergent rides (annually) to grocery stores, food bank, food pantry, places of worship, DMV, library, and exercise classes or gym within a 50-mile radius	All CCC Plus members	No prior authorization required
Diabetes Care	Need Rx from Podiatry or Orthopedic MD One pair of therapeutic shoes or shoe inserts per year (limited to $200 annually)	Age 21 and older with diagnosis of Diabetes	No prior authorization required
Home Delivered Meals	**Mom's Meals** 14 meals/7 days after discharge from hospital	Age 21 and older discharged from hospital	Prior authorization needed from Care Manager
No-Cost Cell Phone provided by Assurance (See link to the right)	Free smartphone with 350 minutes, 3 GB of data and unlimited texts monthly. Free calls to Aetna Better Health Member Services and CCC Plus Helpline. To apply, visit www.aetnabetterhealth.com/virginia/members/phones	Age 18 and older	No prior authorization required

Added Benefit	Services and Limits	Qualifying Members	Approval Criteria
Wellness Rewards	Incentive card: $15: diabetic dilated eye exam $25: wellness exam (to include HbA1c labs and LCL-C screening) $15: woman's mammography $15: cervical cancer screening $25: initial colonoscopy $15: flu shot $25: prostate cancer screening	Age 21 and older	No prior authorization required
Weight Management	12-week certified nutritionist program and six counseling visits	Age 21 and older	No prior authorization required
Personal care attendant	For select high risk members in a nursing facility that transitioned from an acute inpatient stay. 8 hours maximum/per day for a total benefit of 40 hours	Age 21 and older to select high risk members in a nursing facility	Requires prior authorization
Memory care	Two-door alarms and six window locks	Available to members diagnosed with dementia, Alzheimer's Disease, or for eligible children with special needs	Requires prior authorization
Regional Wellness Centers	Regional Wellness Centers are available in each region we serve. These centers function as a one-stop shop where members, caregivers, providers, community organizations and other stakeholders can use our meeting spaces, computers and Internet, or access our community resources database	Available to all members	No prior authorization required
Community Health Workers	Community Health Workers are available in each region to link members to safe housing, local food markets, job opportunities and training, access to health care services, community-based	Available to all members	No prior authorization required

Added Benefit	Services and Limits	Qualifying Members	Approval Criteria
	resources, transportation, recreational activities and other services		
Expanded Respite	10 additional respite hours per month, based on medical necessity	Available to all members receiving respite services	Requires prior authorization

CCC Plus Services Not Covered

The following services are not covered by Medicaid or Aetna Better Health. If a member receives any of the following non-covered services, the member will be responsible for the cost of these services:

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Certain drugs not proven effective
- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Cosmetic treatment or surgery
- Daycare, including companion services for the elderly (except in some home- and community-based service waivers)
- Drugs prescribed to treat hair loss or to bleach skin
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk and as authorized by Aetna Better Health)
- Medical care other than emergency services, urgent services, or family planning services, received from providers outside of the network unless authorized by Aetna Better Health
- Personal care services (except through some home and community-based service waivers or under EPSDT)
- Prescription drugs covered under Medicare Part D, including the Medicare copayment.
- Private duty nursing (except through some home and community-based service waivers or under EPSDT)
- Weight loss clinic programs unless authorized
- Care outside of the United States

If a member receives non-covered services

We cover services when a member is enrolled with our plan and:

- Services are medically necessary, and
- Services are listed as Benefits Covered Through Aetna Better Health, and
- Services are received by following plan rules.

If a member gets services that aren't covered by our plan or covered through DMAS, the member must pay the full cost. If a member is not sure and wants to know if we will pay for any medical service or care, the member has the right to ask us and can call Member Services or speak to their Care Manager to find

out more about services and how to obtain them. The member also has the right to ask for this in writing. If we say we will not pay for certain services, the member has the right to appeal our decision.

CCC Plus Services Covered Through Medicaid Fee-For-Service

DMAS provides the below coverage to members. Providers must bill fee-for-service Medicaid (or a DMAS contractor) for these services. If you have a member who needs help accessing these services, the member's Care Manager can assist. Call **1-855-652-8249 (TTY: 711)**.

Carved-out services

- Dental Services are provided through the *Smiles For Children* program. DMAS has contracted with DentaQuest to coordinate the delivery of all Medicaid dental services. The name of the program is *Smiles For Children*. *Smiles for Children* provides coverage for the following populations and services:
  - For children under age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services.
  - For pregnant women: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, bridges, partials, and dentures, tooth extractions and other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. The dental coverage ends 60 days after the baby is born.
  - For adults age 21 and over, Aetna Better Health offers adult dental care as part of our enhanced benefits package. This benefit covers an exam and cleaning twice per year, annual set of bitewing x-rays, fillings, root canal, or dentures (limited to $525 annually). No prior authorization is required. DentaQuest is our contractor for this program and can be reached at **1-844-824-2018**.

Please note: Aetna Better Health provides coverage for non-emergency transportation for any dental services covered through *Smiles for Children*, as described above.

- Developmental Disability (DD) Waiver Services, including Case Management for DD Waiver Services, are covered through the Virginia Department of Behavioral Health and Developmental Services (DBHDS). The carve-out includes any DD Waiver services that are covered through EPSDT for DD waiver enrolled individuals and transportation to/from DD Waiver services.
- School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's *Individualized Education Program (IEP).* While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. If you have questions about school health services, the parent/guardian of the child should reach out to their child's school administrator to learn more.
- Treatment Foster Care Case Management is managed by Magellan of Virginia and more information is available at http://www.magellanofvirginia.com or by calling **1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711**. The member's Care Manager can also help. Call **1-855-652-8249 (TTY: 711)**.
- Therapeutic Group Home Services for children and adolescents younger than the age of 21. This is

a place where children and adolescents live while they get treatment. Children under this level of care have serious mental health concerns. These services provide supervision and behavioral health care toward therapeutic goals. These services also help the member and their family work towards discharge to the member's home. Additional information about Therapeutic Group Home Services is available on the Magellan website at http://www.magellanofvirginia.com or by calling **1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711**. The member's Care Manager can also help. Call **1-855-652-8249 (TTY: 711)**.

- For members age 21-64, where the member goes into private freestanding Institution for Mental Disease (IMD) or a State freestanding IMD for a Temporary Detention Order (TDO), the state TDO program will pay for the service.

Services that will end a member's CCC Plus enrollment

If a member receives any of the services below, their enrollment with Aetna Better Health in our CCC Plus program will end. Members will receive these services through DMAS or a DMAS Contractor:

- PACE (Program of All Inclusive Care for the Elderly). For more information about PACE, members should talk to their Care Manager or visit http://www.pace4you.org.
- A member resides in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID).
- The member is receiving care in a Psychiatric Residential Treatment Facility (children under 21). Additional information about Psychiatric Residential Treatment Facility Services is available on the Magellan website at http://www.magellanofvirginia.com or by calling **1-800-424-4046 TDD: 1-800-424-4048 or TTY: 711**. The member's Care Manager can also help. Call **1-855-652-8249 (TTY: 711)**.
- The member resides in a Veteran's Nursing Facility.
- The member resides in one of these State long term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock.

CCC Plus: How to Access Long-Term Services and Supports (LTSS)

Aetna Better Health provides coverage for long-term services and supports (LTSS) including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. LTSS can provide assistance that helps the member live in their own home or other setting of their choice and improves their quality of life.

Examples of services include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities (through a home and community based waiver), but also in nursing facilities. If a member needs help with these services, they can reach out to their Care Manager who will help in the process to find out if the member meets the Virginia eligibility requirements for these services.

CCC Plus Waiver

Some Members may qualify for home and community-based care waiver services through the Commonwealth Coordinated Care Plus Waiver (formerly known as the Elderly or Disabled with Consumer Direction and Technology Assistance Waivers).

The CCC Plus Waiver is meant to allow a Member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus Waiver services, the member may choose how to receive personal assistance services. Members have the option to receive services through an agency (known as agency directed) or may choose to serve as the employer for a personal assistance attendant (known as consumer-directed).

CCC Plus Waiver Services may include:

- Private duty nursing services (agency directed)
- Personal care (agency or consumer-directed)
- Respite care (agency or consumer-directed)
- Adult day health care
- Personal emergency response system (with or without medication monitoring)
- Transition coordination/services for Members transitioning to the community from a nursing facility or long stay hospital. To facilitate a successful transition from the nursing facility to the member's home, Aetna Better Health offers eligible members the No Place Like Home Grant and Rental Assistance that includes home environmental assessments, home modifications, utilities, and rent payments for the initial months, hoarding interventions, cleaning and handyman services, and pest control.
- Assistive technology
- Environmental modifications

Individuals enrolled in a DD Waiver should refer to the DD Waiver section for more information.

CCC Plus: What is Consumer-Directed Care?
Consumer-directed care refers to personal care and respite care services provided under the CCC Plus Waiver. These are services in which the member or their family/caregiver is responsible for hiring, training, supervising, and firing of their attendant. Members will receive financial management support in their role as the employer to assist with enrolling their providers, conducting provider background checks, and paying providers. If a member has been approved to receive CCC Plus Waiver services and would like more information on the consumer-directed model of care, their Care Coordinator can assist the member with these services.

The member's Care Manager will also monitor the member's care as long as they are receiving CCC Plus Waiver services to make sure the care provided is meeting your daily needs.

In order to obtain service authorizations for CCC Plus Waiver services, the member should call their personal Clinical Care Manager or our Member Service Department at **1-855-652-8249 (TTY: 711)**. The following services require a service authorization but are not limited to: Home and Community based services including Agency Directed Personal Care, Consumer directed personal care, Respite Care, Adult Day Health Care, and Personal Emergency Response System (PERS).

Nursing Facility Services
If a member is determined to meet the coverage criteria for nursing facility care and chooses to receive long term services and supports in a nursing facility, Aetna Better Health will provide coverage for nursing facility care. If the member has Medicare, Aetna Better Health will provide coverage for nursing facility

care after the member exhausts their Medicare covered days in the nursing facility, typically referred to as skilled nursing care.

If the member is in a nursing facility, they may be able to move from the nursing facility to their own home and receive home and community-based services if they choose. If the member is interested in moving out of the nursing facility into the community, the member should talk to their Care Manager who can help. The Care Manager is available to work with the member, the member's family, and the discharge planner at the nursing facility if the member is interested in moving from the nursing facility to a home or community setting.

If the member chooses not to leave the nursing facility, they can remain in the nursing facility for as long as they are determined to meet the coverage criteria for nursing facility care. In order to obtain service authorizations related to nursing facility services, the member should call their Clinical Care Manager or our Member Services at **1-855-652-8249 (TTY: 711)**. The following service requires a service authorization: Custodial Care Nursing Facility Admissions.

Screening for LTSS
Before a member can receive LTSS, the member must be screened by a community based or hospital screening team. A screening is used to determine if the member meets the level of care criteria for LTSS. The member should contact their Care Manager to find out more about the screening process in order to receive LTSS.

Freedom of Choice
If a member is approved to receive LTSS, they have the right to receive care in the setting of their choice:

- In the member's home, or
- In another place in the community, or
- In a nursing facility.

The member can choose the doctors and health professionals for their care from our network. If the member prefers to receive services in their home under the CCC Plus Waiver, for example, they can choose to directly hire their own personal care attendant(s), known as consumer-directed care as described above. Another option the member has is to choose a personal care agency in our network, where the agency will hire, train, and supervise personal assistance workers on the member's behalf, known as agency direction. Members also have the option to receive services in a nursing facility from our network of nursing facility providers.

CCC Plus: How to Get Services if a member is in a Developmental Disability Waiver

If a member is enrolled in one of the DD waivers, they will be enrolled in CCC Plus for their **non-waiver services**. The DD waivers include:

- The Building Independence (BI) Waiver,
- The Community Living (CL) Waiver, and
- The Family and Individual Supports (FIS) Waiver.

Aetna Better Health will only provide coverage for the member's non-waiver services. Non-waiver services include all of the services listed above in CCC Plus Benefits Covered through Aetna Better Health

with an exception: If a member is enrolled in one of the DD Waivers, they would not also be eligible to receive services through the CCC Plus Waiver.

DD Waiver services, DD and ID targeted case management services, and transportation to/from DD waiver services, will be paid through Medicaid fee-for-service as "carved-out" services. The carve-out also includes any DD waiver services that are covered through EPSDT for DD waiver enrolled individuals under the age of 21.

If a member has a developmental disability and need DD waiver services, they will need to have a diagnostic and functional eligibility assessment completed by their local Community Services Board (CSB). All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in the member's person-centered individualized service plan.

The DD waivers have a waitlist. Individuals who are on the DD waiver waitlist may qualify to be enrolled in the CCC Plus Waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in the member's community. For more information on the DD Waivers and the services that are covered under each DD Waiver, visit the Department of Behavioral Health and Developmental Services (DBHDS) website at http://www.mylifemycommunityvirginia.org or call **1-844-603-9248**. The member's Care Manager will work closely with the member and their DD or ID case manager to help the member get all of their covered services.

Transportation to and from DD Waiver Services
If a member is enrolled in a DD Waiver, Aetna Better Health provides coverage for their transportation to and from *non-waiver services.* Members should call LogistiCare at **1-800-734-0430** for transportation to your ***non-waiver services***.

Transportation to DD Waiver services is covered by the DMAS Transportation Contractor. Members can find out more about how to access transportation services through the DMAS Transportation Contractor on the website at http://transportation.dmas.virginia.gov or by calling the Transportation Contractor. Transportation for routine appointments are taken Monday through Friday between the hours of 6:00 AM to 8:00 PM. The DMAS Transportation Contractor is available 24 hours a day, 7 days a week to schedule urgent reservations at **1-866-386-8331 or TTY 1-866-288-3133 or 711** to reach a relay operator.
If the member has problems getting transportation to DD waiver services, they may call their DD or ID Waiver case manager or the DMAS Transportation Contractor at the number above. The member can also call their Aetna Better Health Care Manager. Their Care Manager will work closely with the member and their DD or ID Waiver case manager to help get the services that needed. Member Services is also available to help at **1-855-652-8249 (TTY: 711)**.

How we educate members on their benefits and services

Aetna Better Health has numerous ways to inform members about covered health services. In conjunction with the provision of covered services, Aetna Better Health is also responsible for the following:

- Placing a strong emphasis on programs to enhance the general health and well-being of members. Specifically, we develop and implement programs that encourage members to maintain a healthy diet, engage in regular exercise, get an annual physical examination, and avoid all tobacco use
- Making health promotion programs available to members
- Promoting the availability of health education classes for members
- Providing education for members with, or at risk for, a specific disability or illness
- Providing education to members, members' families, and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities
- Upon request from DMAS, collaborate on projects that focus on improvements and efficiency in the overall delivery of health services.

No program information document shall be used unless it achieves a Flesch total readability score of 40 or better (at or below a 12th grade educational level) for Medallion 4.0 members or a sixth grade reading level for CCC Plus members. The document must set forth the Flesch score and certify compliance with this standard. These requirements do not apply to language that is mandated by federal or state laws, regulations, or agencies.

All documents are available in alternate formats and in non-prevalent languages, including:

- Member handbook: A comprehensive document that explains all covered benefits and services and exclusions and limitations
- Public website: General information and member handbook are available online
- Member online portal: A web portal providing members easy access to health care information and materials. The member portal is a secure, password-protected site that ensures confidential information is only available to the member.
- Member newsletter: A quarterly member publication featuring articles about covered services including standard and enhanced benefits, as well as articles focused on the importance of immunizations, well-child check-ups, age-appropriate health screenings, care and disease management, and when to seek care at your PCP, urgent care clinic, or emergency room, etc.

Aetna Better Health's teams also communicate covered benefits and services to members on a regular basis.

- Member Services: Representatives are trained and dedicated to Virginia's Medicaid line of business. Member Services representatives describe benefits to members and answer questions. Interpretation services are available in several languages.
- Appeals and Grievances: assists members with completing the grievance and appeal process when dissatisfied with services or benefit reductions.
- Care Management: works closely with individual members to develop and execute care plans.
- Prior Authorization: Prior Authorization staff work with the provider community to process referral and prior authorization requests.
- Outreach Coordinators: Internal staff in our Community Development and Outreach team partner with the community across the Commonwealth to help support our members' understanding of Medicaid covered services.
- Network Providers: training materials and the provider manual include Virginia Medicaid covered services information.
- Member Advisory Committee (MAC): MAC is an integrated health plan and member committee that meets regularly to discuss Aetna Better Health benefits and services, and to provide feedback on Aetna Better Health benefits and services, as well as review materials, and talk about how we

can work better with our provider community to get members the care they need when they need it.

Important Information Regarding Medicaid Expansion

What makes someone eligible to be a Medicaid Expansion member?

An adult can be eligible for Medicaid Expansion if they are 19 years of age to 64 years of age and you meet all of the following categories:

- Not already eligible for Medicare coverage,
- Not already eligible for Medicaid coverage through a mandatory coverage group (you are pregnant or disabled, for example)
- Income does not exceed 138% of the Federal Poverty Level (FPL)

Medicaid eligibility is determined by the applicant's local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Applicants can contact their local DSS eligibility worker or call Cover Virginia at 1-855-242-8282 (TDD: 1-888-221-1590) with any Medicaid eligibility questions, or visit Cover Virginia on the web at http://www.coverva.org.

If eligible, Medicaid Expansion members will enroll in either a Medallion 4.0 or CCC Plus program. This is determined by eligibility criteria and whether a member meets a medically complex criteria.

Medicaid Expansion benefits and services

In addition to the standard Medicaid benefits and services available to all Medicaid members, Medicaid Expansion members will also receive the following four health benefits:

- Annual adult wellness exams
- Individual and group smoking cessation counseling
- Nutritional counseling if you are diagnosed with obesity or chronic medical diseases
- Recommended adult vaccines or immunizations

Within four months after a member enrolls with us, Aetna Better Health will contact the member or the member's authorized representative via telephone or in person to ask some questions about their health needs and social circumstances. These questions will make up what is called the "Health Screening." Aetna Better Health will ask about any medical conditions the member currently has or has had in the past, their ability to do everyday things, and their living conditions. The member's answers help Aetna Better Health understand their needs and identify whether or not the member has medically complex needs.

If a Medicaid Expansion member meets the medically complex criteria, they will transfer from the Medicaid Managed Care Medallion 4.0 program to the CCC Plus program. If it is determined the member does not have medically complex needs, the member will remain in the Medallion 4.0 program. If we are unable to contact the member or the member refuses to participate in the entire health screening, the member will remain enrolled in the Medallion 4.0 program.

Medallion 4.0 and CCC Plus: Other Services

Behavioral Health Services

Behavioral health services offer a wide range of treatment options for individuals with a mental health or

substance use disorder. Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues as well as using substances at some time in their lives. These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in the member's home or in the community, for a short or long timeframe, and all are performed by qualified individuals and organizations.

Aetna Better Health members can reach out to their Care Manager or Member Services if they need help scheduling an appointment to speak with a behavioral healthcare professional.

Some behavioral health services are covered through Magellan, the DMAS Behavioral Health Services Administrator (BHSA). The member's Care Manager will work closely with the BHSA to coordinate the services, including those that are provided through the BHSA.

For members to access certain behavioral health services, certain services require preauthorization. For preauthorization, call **1-800-279-1878 (TTY: 711)** for Medallion 4.0 members and **1-855-652-8249 (TTY: 711)** for CCC Plus members. These include but are not limited to:

- Outpatient services in a psychiatrist's or licensed clinical psychologist's private office, certified hospital outpatient departments, and in the community mental health clinics approved and/or operated by the Virginia Department of Behavioral Health and Developmental Services.
- Medically necessary outpatient individual, family and group mental health and substance abuse treatment services.
- Short-term inpatient hospital services are covered for members under the age of 21 in participating hospitals when preauthorized by the Aetna Better Health mental health provider. Hospital stays for the treatment of medical conditions that relate to substance abuse (like acute gastritis, seizures, pancreatitis, and cirrhosis) need to be preauthorized by us.
- Psychological tests, when related to an apparent or diagnosed psychiatric illness and as part of your doctor's plan for deciding what the mental illness or disease is and how to treat it.
- Children who have special needs for medically necessary assessment and treatment services, including children who have been victims of child abuse and neglect, can get this care if: (1) the services are delivered by a doctor or provider whose specialty is in the diagnosis and treatment of child abuse and neglect; (2) the services are provided by a doctor or provider who has similar expertise. A provider who meets these standards will be verified by DMAS.
- Services required by a Temporary Detention Order (TDO) are covered for members up to 96 hours.
- All care given in a free-standing psychiatric hospital is covered for members up to the age of 21 and over the age of 64. When a child is admitted as a result of an EPSDT screening, a certification of the need for care must be completed as required by federal and state law

Addiction and Recovery Treatment Services (ARTS)

Aetna Better Health offers a variety of services that help individuals who are struggling with using substances, including drugs and alcohol. Addiction is a medical illness, just like diabetes, that many people deal with and can benefit from treatment no matter how bad the problem may seem. These services include settings in inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options, counseling services, and behavioral therapy options are also available if the member is dealing with using prescription or non-prescription drugs. Other options that are helpful include peer services (someone who has experience similar issues and in recovery), as well as care coordination

services.

As a provider, you will need to submit the ARTS Service Authorization Review Form for the following services that require prior authorization by Aetna Better Health:

- Intensive Outpatient Services
- Partial Hospitalization Services
- Clinically Managed Low Intensity Residential Services
- Clinically Managed Population Specific High Intensity Residential Services
- Clinical Managed High Intensity Residential Services
- Medically Monitored Intensive Inpatient Services
- Medically Managed Intensive Inpatient Services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

What is EPSDT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a federally mandated Medicaid benefit that provides comprehensive and preventive health care services for children under age 21. If a parent/guardian has a child who is an Aetna Better Health member under age 21, EPSDT provides appropriate preventive, dental, behavioral health, developmental, and specialty services. It includes coverage for immunizations, well child visits, lead investigations, private duty nursing, personal care, and other services and therapies that treat or make a condition better. It will also cover services that keep the child's condition from getting worse. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid.

Getting EPSDT Services

Aetna Better Health provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by Aetna Better Health. For any services not covered by Aetna Better Health, the member can get these through the Medicaid fee-for-service program.

Aetna Better Health is dedicated to ensuring all Medicaid-eligible members under the age of 21 receive EPSDT services and that their parents, guardians, and providers are using the resources effectively. Our EPSDT program promotes collaboration with members, providers, State agencies, community organizations, and other stakeholders to achieve this goal for our members.

To help ensure utilization, we facilitate EPSDT well-child visits for eligible members under the age of 21. To identify health and developmental problems, early and periodic screenings are scheduled in accordance with the Commonwealth through consultation with medical providers involved in the child's health care.

EPSDT can be particularly important to children who are on the waiting list for the Developmental Disabilities Waiver or the Intellectual Disability Waiver. Receiving services such as skilled nursing or personal care may be needed while the child is waiting for access to the waiver.

Additionally, young adults with disabilities between the ages of 18 and 21 often are eligible for Medicaid when they become eligible for SSI. These young adults may especially benefit from EPSDT. Full EPSDT visits include:

- Comprehensive health and developmental history
- Comprehensive unclothed physical examination
- Appropriate immunizations
- Laboratory services such as lead toxicity screening

- Dental, vision and hearing screenings
- Other screenings as determined to be needed by a provider
- Health education and anticipatory guidance as a required component of screening services

Please call our Member Services Department at **1-800-279-1878 (TTY: 711)** for Medallion 4.0 members and **1-855-652-8249 (TTY: 711)** for CCC Plus members to obtain preauthorization for any EPSDT services included but not limited to:

- Durable Medical Equipment (DME)
- Genetic testing
- Home based services including personal care
- Imaging (scans)
- Injectables
- Inpatient services
- Neuropsychological testing
- Orthotics/Prosthetics
- Outpatient surgery
- Psychological testing
- Services from providers not in your network
- Sleep studies
- Therapies
- Nuclear Radiology
- Transplant consultations, evaluations and testing/transplant procedures

Network providers are subject to Aetna Better Health's documentation requirements for EPSDT services. EPSDT services shall also be subject to the following additional documentation requirements:

- The medical record shall include the age-appropriate screening provided in accordance with the periodicity schedule.
- Documentation of a comprehensive screening shall at a minimum, contain a description of the components described below. Aetna Better Health recommends that providers send reminders to parent when screenings, immunizations, and follow-up services are due.

Provider guidelines for EPSDT screenings

Providers should use the following guidelines to provide comprehensive EPSDT services to Aetna Better Health members.

Comprehensive, periodic health assessments or screenings, from birth through age 20 at intervals, which meets reasonable standards of practice, as specified in the EPSDT medical periodicity schedule established by DMAS. The medical screening shall include:

- A comprehensive health and developmental history, including assessments of both physical and mental health development.
- A comprehensive unclothed physical examination, including vision and hearing screening, dental inspection, height, weight and BMI assessment and a nutritional assessment.
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations must be administered
- Appropriate laboratory tests at participating lab facilities. The following recommended sequence of screening laboratory examinations should be provided by Aetna Better Health participating

providers; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.
- Hemoglobin/hematocrit.
- Urinalysis.
- Tuberculin test.
- Blood lead assessment using blood level determinations as part of scheduled periodic health screenings appropriate to age and must be done for children according to the following schedule:
    - Between 12 months and 24 months of age.
    - Between 24 and 72 months of age if the child has not previously been screened for lead poisoning.
- All screenings shall be done through blood lead level determinations.
- Results of lead screenings, both positive and negative, shall be reported to the Virginia immunization registry.
- Health education/anticipatory guidance.
- Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.
- EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the following schedule:

EPSDT service	Member Age	Frequency
Neonatal exam	9 months	3 years
Under 6 weeks	12 months	4 years
2 months	15 months	5 years
4 months	18 months	6 years
6 months	2 years	Bi-annually from age 7 through 20 years for Medicaid

For children who have been tested, the following questions are intended to assist providers and nurse practitioners in determining if further testing is necessary in addition to that completed at the mandated ages.

- Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint? This could include day care, preschool, or home of a relative.
- Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?
- Does the child have a brother or sister (or playmate) with lead poisoning?
- Does the child live with an adult whose job or hobby involves lead?
- Does the child's family use any home remedies that may contain lead?

For further information on lead screening, please contact the Centers for Disease Control (CDC) at **800-232-4636**. Publications and other materials concerning blood lead screening may be obtained from the Virginia DMAS Childhood Lead Poisoning Prevention Program.

Early Intervention Services

If a parent/guardian of a child under the age of 3 who is an Aetna Better Health member is not learning or developing like other babies and toddlers, the child may qualify for early intervention services. Early intervention services include services that are designated to meet the developmental needs of an infant or

toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development. The services include speech therapy, physical therapy, and occupational therapy. The first step is meeting with the local Infant and Toddler Connection program in the member's community to see if the child is eligible. Children from birth to age three are eligible if he/she has:

1. A 25% developmental delay in one or more areas of development
2. Atypical development
3. A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay

For more information, members should reach out to their Care Manager. If the child is enrolled in Aetna Better Health, we provide coverage for early intervention services, including assistance with transportation and appointment scheduling.

A Care Manager will work closely with the parent/guardian and the Infant and Toddler Connection program to help the member access these services and any other services that the child may need. Information is also available at **www.infantva.org** or by calling **1-800-234-1448**. Our Care Management staff can be reached at **1-800-279-1878 (TTY: 711)** for Medallion 4.0 members and **1-855-652-8249 (TTY: 711)** for CCC Plus members.

Transportation services

Transportation service is a covered benefit for eligible Aetna Better Health members when necessary to receive non-emergent medically necessary health services. Transportation includes but is not limited to:

- Public transportation
- Taxicab
- Ambulance
- Gas reimbursement, or
- a wheelchair van

Non-emergent transportation applies to all CCC Plus and Medallion 4.0 members, including FAMIS. Members can request non-emergency transportation by phone at **1-800-734-0430** or online at **https://member.logisticare.com**. These Guidelines to determine transportation necessity:

- Members are asked to give a three-day notice when requesting non-urgent transportation.
- Members must be eligible with Aetna Better Health on date of the scheduled appointment.

Providers or members may contact transportation vendor to arrange for transportation for medically necessary non-emergent health services. Non-emergent transportation to covered services is available to eligible members 24 hours per day, seven days per week, 365 days per year, including evening, weekends, and holidays.

Criteria for non-emergent transportation:

- Transportation is a covered benefit for covered non-emergent medical appointments, trips to the pharmacy associated with a medical appointment, and specified Aetna Better Health/Case Management outreach events.
  - More than one additional passenger will require member Service Supervisor approval.
- If the member is a single caregiver with more than one minor child in his/her care, the plan authorizes vendor to transport the additional minor children.

- Members under age 16 must be accompanied by an adult at least 21 years or older, with the exception of pregnant members whose trip will not require Member Services Supervisor approval.
- Trips to a PCP that exceed thirty miles or trips to a specialist that exceed fifty miles one way require prior approval from Aetna Better Health Member Services Supervisor.
- Out-of-state trips require approval from the health plan. Fax request for authorization to Health Services **844-797-7601**.

Information regarding transportation to and from DD Waiver Services is located under CCC Plus: How to Get Services if a member is in a Developmental Disability Waiver.

Vision services

Participating providers should perform periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum according to DMAS' EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including the need for eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination, and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

Hearing services

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who do not pass the newborn hearing screening, those who are missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Participating providers should perform periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in DMAS' EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

Dental services through the Smiles for Children program

Dental screening in this context shall mean, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives his or her one-year screening. A referral to a dentist shall be mandatory at three years of age and annually thereafter, through age 20 for Medicaid members and through the age of 18 for children with FAMIS.

Oral examination includes visual and tactile examination of all intra-oral hard and soft tissues and teeth for all children for obvious abnormalities, such as cavities, inflammation, infection, or malocclusion. Children should be referred to dentists for the following reasons:

- Over the age of one year
- Evidence of infection, inflammation, discoloration, malformation of the dental arches
- malformation or decay of erupted teeth

Pregnancy Benefit

Pregnant women who are 21 years of age and older in Medicaid or FAMIS can get dental benefits. These dental benefits are available through the Smiles for Children program. Benefits include:

- Cleanings
- Exams
- Fillings
- Crowns, bridges, partials, and dentures
- Root canals
- X-rays
- Extractions and other oral surgeries
- Anesthesia

Braces are not covered.

These benefits will stop at the end of the month following the 60th day after the member has had the baby. For example, if the member gives birth on May 15, the dental benefits will end on July 31.

To schedule a dental appointment with a participating Smiles for Children provider, members should call DentaQuest at **888-912-3456**.

Oral health screening and fluoride varnish

Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a *HCFA 1500* form shall be covered. This program is intended for medical providers, such as pediatricians, family practitioners, and nurse practitioners who treat members up to age three (0 — 35 months). Fluoride varnish can be applied to teeth up to four times a year. The procedure code for fluoride varnish application is D1206. The fluoride varnish application is a separate reimbursement. The oral health screen is part of the well-child visit performed by the medical provider. For more information about how to apply fluoride varnish, providers should contact their local health departments.

Women's Health

Women's health specialists

Aetna Better Health provides female members direct access to women's health specialists for routine and preventive health care services. Routine and preventive health care services include, but are not limited to prenatal care, breast exams, mammograms, and pap tests. Direct access means that Aetna Better Health cannot require women to obtain a referral or prior authorization as a condition to receiving such services from specialists in the network. Direct access does not prevent Aetna Better Health from requesting or requiring notification from the provider for data collection purposes. They may also seek these services from a participating provider of their choice, if their PCP is not a women's health specialist.

Women's health specialists include, but are not limited to, obstetricians, gynecologists, nurse practitioner, and certified nurse midwives.

In terms of appointment standards, pregnant members should be able to make an appointment to see an OB/GYN as follows:

- First trimester (first 3 months): within fourteen (14) calendar days of request
- Second trimester (3 to 6 months): within seven (7) calendar days of request
- Third trimester (6 to 9 months): within five (5) business of request

- High-Risk pregnancy: within three (3) business days of request

Obstetric and Gynecologic Services

Aetna Better Health covers routine and medically necessary obstetric and gynecologic (OB/GYN) health care services under Medicaid for covered members. Health care services means the full scope of medically necessary services provided by the obstetrician gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists.

Aetna Better Health will reimburse OB/GYN services at least the amount reimbursed under the Medicaid fee schedule. If the female member's designated primary care physician is not a women's health specialist, Aetna Better Health is required to provide the member with direct access to a women's health specialist within the provider network for covered routine and preventive women's care services.

Note that a pregnant minor is deemed an adult for the purpose of consenting for herself and her child to both survival and medical treatment relating to the delivery as well as treatment for her child pursuant to the Code of Virginia § 54.1-2969 (E), as amended.

Aetna Better Health permits any female member age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the Code of Virginia, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without prior authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists.

Sterilizations

Providers shall comply with the requirements set forth in 42 CFR § 441, Subpart F, as amended, and shall comply with the thirty-calendar day waiting period requirement as specified in *Code of Virginia*, § 54.1-2974. The consent form of 42 CFR § 441.258 (see attachments) must be documented prior to the performance of any sterilization. Specifically, there must be documentation of the member being informed, the members giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed.

The patient must be at least 21 years of age, mentally competent and must wait a minimum of 30 days after signing the consent form but no longer than 180 days. This form is available in English and Spanish.

Sterilization consent forms

The *Virginia Department of Medical Assistance Services Sterilization Consent Form* is included in this manual. Please see the Attachments Section. It may also be downloaded by the provider directly from the DMAS Provider Services portal. The surgeon shall submit a properly completed and legible form to Aetna Better Health before payment of claims can be considered. For additional information, contact the Prior Authorization department at **1-800-279-1878 (TTY: 711)** for Medallion 4.0 members or **1-855-652-8249 (TTY: 711)** for CCC Plus members.

Hysterectomies

All hysterectomies require preauthorization. Federal regulations require that members be informed before the operation that a hysterectomy will leave them sterile. As a result, all patients scheduled for a

hysterectomy must sign the *Acknowledgment of Receipt of Hysterectomy* Information form. A copy of this form is included in the Attachment Section or can be obtained through DMAS or through your Provider Relations Representative. The Hysterectomy Acknowledgment Form must be submitted with claims relating to hysterectomies to ensure reimbursement. In the event of an emergency surgery in which the required forms were not signed, a provider's statement that prior acknowledgment was not possible is required for claims reimbursement.

Mammograms

Aetna Better Health covers screening mammograms for female members ages forty and over, consistent with the guidelines published by the American Cancer Society, and for FAMIS members as medically appropriate. The Contractor must meet all requirements set forth in 12 VAC 30-50-220.

a. Aetna Better Health will provide coverage for at least a forty-eight (48) hour hospital stay following a radical or modified radical mastectomy and not less than twenty-four (24) hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 631 of 1998 Virginia Acts of Assembly, § 32.1-325 (A) (1) through §32.1-325 (A)(25) of the Code of Virginia.
b. Aetna Better Health will cover reconstructive breast surgery in accordance with 12 VAC 30-50-140.
c. Aetna Better Health will cover breast prostheses following medically necessary removal of a breast for any medical reason as set forth in 12 VAC 30-50-210.

Maternity services/Childcare management

Baby Matters is a program dedicated to promoting healthier babies and protecting the well-being of the mother. As a member of Aetna Better Health, all expectant mothers are eligible to receive our pregnancy health guide. *Baby Matters'* educational information follows an expectant mother through prenatal care, delivery, and postpartum care. At the member's first prenatal visit, the provider will complete and fax a *Maternity Notification Form***.** The OB Care Manager will evaluate the risk factors on this form. Care Management and educational interventions will be provided to the member, as appropriate. This care is designed to serve as a health benefit and is not a substitute for or intended to interfere with the mother's current medical care.

Family planning services

Aetna Better Health members have direct access for family planning services without a referral and may also seek family planning services at the provider of their choice (in or out of network).

The following services are included:

- Annual gynecological exam
- Annual pap smear
- Lab services
- Contraceptive supplies, devices, and medications for specific treatment
- Contraceptive counseling

Treatment for STDs

Aetna Better Health members can access any participating provider or Virginia Medicaid provider for treatment of a sexually transmitted disease without prior approval from Aetna Better Health.

Newborns

For Aetna Better Health and Virginia Medicaid, claims for a newborn must be billed under his/her own member ID number and not the mother's number. To determine a newborn's temporary member identification number for Aetna Better Health, please call Member Services. Until the state and Aetna Better Health issue their permanent Medicaid numbers for the newborn, the temporary number must be used to bills claims. If Aetna Better Health doesn't have the newborn's name, the child is loaded in our system as baby girl/boy — with the mother's last name.

Coverage for Newborns Born to Moms Covered Under Medallion 4.0
Parents must contact DMAS to have the newborn added as permanent. For FAMIS members, the parents need to contact FAMIS to add the newborn if permanent enrollment has not been established within the 30- to 90-day period and the newborn policy is termed, the member is no longer eligible for coverage.

Babies born to mothers enrolled in Aetna Better Health will automatically be enrolled into Aetna Better Health. The baby will be covered for the birth month plus 2 additional months, even if the member does not stay enrolled with our plan.

Once the member has their baby, the member will need to enroll their baby as quickly as possible for Medicaid. Medicaid eligibility rules ensures continuous enrollment for the member's baby up to 12 months following birth. It is very important the member calls their local Department of Social Services (DSS) to report the birth of their child and get a Medicaid/FAMIS Plus ID card for their baby.

Members can do this by:

- Calling the Cover Virginia Call Center at **1-855-242-8282** to report the birth of their child over the phone, or
- Contacting their local DSS to report the birth of their child.

The member will be asked to provide their information and their infant's:

- Name
- Date of Birth
- Race
- Sex
- The infant's mother's name and Medicaid ID number

If the baby does not have a Medicaid/FAMIS Plus ID number by the end of the third month following birth, the baby will lose coverage.

Coverage for Newborns Born to Moms Covered Under CCC Plus

When first enrolled in Medicaid, the member's baby will be able to access health care through the Medicaid fee-for-service program. This means that the member can take their baby to any provider in the Medicaid fee-for-service network for covered services. Members will receive additional information in the mail about how their baby will receive Medicaid coverage from DMAS. However, just as with Medallion 4.0, the member will need to report the birth of their baby as quickly as possible to enroll their child into Medicaid.

Members can do this by:

- Calling the Cover Virginia Call Center at **1-855-242-8282** to report the birth of their child over the phone, or

- Contacting their local DSS to report the birth of their child.

Foster care program

The Commonwealth of Virginia mandates foster care children to be assigned to managed care health plans. The benefit of being assigned to a managed care organization includes such additional services as one-on-one care management, coordination of health care services, 24-hour-nurse advice line, comprehensive health risk assessments, and translation services. Current foster care policy provides general health requirements for supervising agencies to ensure that each child has:

- A physical examination (well child visit, including behavioral health screening) within thirty days of initial foster care placement
- A dental exam within ninety days of initial foster care placement
- Current immunizations
- Children under the age of 3 are referred to Early Intervention for an assessment

There are also policy requirements to document all medical, dental, and mental health services received, including information regarding prescriptions, and to maintain a medical passport for each child that is provided to caregivers. Documentation of a child's present health status and medical needs is required from the onset of a child's placement into foster care.

Therefore, Aetna Better Health is going to need your assistance in ensuring timely access to care within your office for these children. If you are asked to provide an exam for a child in foster care and are unable to meet the above stated guidelines, please contact our Member Services department. We will work with the caregiver to have the child seen at another provider's office.

Your current provider contract with us will enable Aetna Better Health and our foster care membership to utilize you as a network provider. There is no contract amendment necessary to reflect your participation. All terms and conditions of your existing agreement with Aetna Better Health, including but not limited to those regarding your reimbursement, will remain the same for the foster care program.

Other medically necessary healthcare services

Participating providers should perform such other medically necessary health care, diagnostic services, treatment, and other measures as needed to correct or ameliorate defects and physical, mental, and substance abuse illnesses and conditions discovered by the screening services.

Referrals

If a problem is found or suspected during a well-child visit, the (suspected) problem must be diagnosed and treated as appropriate. This may mean referral to another provider or self-referral for further diagnosis and treatment.

It is not always possible to complete all components of the full medical screening service. For example, immunizations may be medically contraindicated or refused by the caregiver. The caregiver may also refuse to allow their child to have a lead blood level test performed. When this occurs, an attempt should be made to educate the caregiver with regard to the importance of these services. If the caregiver continues to refuse the service, the child's medical record must document the reason the service was not provided. By fully documenting in the child's medical record the reason these services were not provided, the Provider may bill a full medical screening service even though not all components of the full medical screening service were provided.

Home health care and DME

Home health care, DME, home infusion and orthotics/prosthetic services may require prior authorization. All services should be coordinated with the member's PCP or the referring provider specialist in accordance with his/her plan of treatment based on medical necessity, available benefit, and appropriateness of setting and network availability.

Emergency services

Prior approval by the member's PCP and medical/surgical plan is not required for receipt of emergency services. Education of the member is necessary to ensure they are informed regarding the definition of an "emergency medical condition," how to appropriately access emergency services, and encourage the member to contact the PCP and plan before accessing emergency services. Aetna Better Health Member Services and Care Management will also assist in educating members regarding Emergency Services.

An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity, (including severe pain), that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.
d. Serious harm to self or others due to an alcohol or drug abuse emergency.

Aetna Better Health must be notified of an emergency admission within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday. However, earlier notification greatly facilitates the utilization review process and allows Aetna Better Health to determine during the stay whether or not a medical criterion for coverage is met.

If you are unsure regarding the necessity for preauthorization, please call Health Services at **1-800-279-1878 (TTY: 711)** for Medallion 4.0 members and **1-855-652-8249 (TTY:711)** for CCC Plus members. For weekend or after-hours admissions, you can call Health Services on the next working day at **1-800-279-1878 (TTY: 711)** for Medallion 4.0 members and **1-855-652-8249 (TTY:711)** for CCC Plus members. For urgent/emergent issues after hours, call **1-800-279-1878 (TTY: 711)** for Medallion 4.0 members and **1-855-652-8249 (TTY: 711)** for CCC Plus members and follow the prompts for afterhours preauthorization, and you will be directed to an on-call nurse that can assist you. You may also fax to **844-797-7601**.

Members that inappropriately seek routine and/or non-emergent services through emergency department visits will be contacted by Aetna Better Health and educated on visiting their PCP for routine services and/or treatments. Use of ground ambulance transportation under the prudent layperson's definition of emergency will not require authorization for the ambulance service.

Pharmacy

Aetna Better Health pharmacy benefit is intended to cover medically necessary prescription products for self-administration in an outpatient setting. The pharmacy benefit provides FDA approved outpatient prescription medications that are clinically proven to be safe and effective.

The formulary assists in ensuring quality of member care and the principal consideration in the selection of covered drugs is to provide safe and effective medications for all disease states. Providers are encouraged to refer to the formulary when selecting prescription drug therapy for eligible members.

For more information regarding pharmacy benefits, refer to Chapter 9: Pharmacy.

Vaccines for Children (VFC) program

Aetna Better Health facilitates the payment of allowable fees for the administration of childhood immunizations to see that vaccines administered to enrolled and eligible members under the Vaccines for Children (VFC) program are appropriately reimbursed. Aetna Better Health will reimburse participating providers for administration costs for vaccines provided to eligible members under the VFC program. Please check VFC program eligibility with the state of Virginia.

What is the VFC program?

VFC helps families by providing free vaccines to doctors who serve eligible children. The program is administered at the national level by the CDC through the National Immunization Program. The CDC contracts with vaccine manufacturers to buy vaccines at reduced rates.

States and eligible U.S. projects enroll providers who serve eligible patients up to and including age 18 years, providing routine immunizations with little to no out-of-pocket costs.

For more information about the Virginia VFC Program and how to join, please visit **https://www.vdh.virginia.gov/immunization/vvfc** or call **1-800-568-1929**.

Women, Infants and Children (WIC) nutrition program

Aetna Better Health benefits do not include WIC. Aetna Better Health benefits do not provide transportation for you to pick up WIC checks. The Virginia Department of Health provides the WIC program. We will send expectant mothers' information on WIC in their Baby Matters material. If you want to find out more about WIC, call your local health department, or call toll-free at **888-942-3663**.

How can you obtain WIC materials, forms, and information?

For WIC materials and forms or for more information, you can download many of the WIC program forms and education materials at:

- **www.vdh.virginia.gov/ofhs/dcn/wic/WICVA/index.html**
- **https://wicworks.fns.usda.gov/topics.html**

Interpretation services

Aetna Better Health provides interpreter services for non-English speaking or hearing and visually impaired members. We created a section on our website where you can learn more about our multi-language translation and interpreter services available to members.

DMAS is responsible for notifying Aetna Better Health at the time of the member's enrollment about this need. Aetna will also screen during member contacts if interpretation services are needed to assist more efficiently. Aetna Better Health will provide, upon request, alternative formats of all member related materials. Providers and members may inquire about interpretive services in their community by contacting Member Services at **1-800-279-1878 (TTY: 711)** for Medallion 4.0 members and **1-855-652-8249 (TTY: 711)** for CCC Plus members.

Aetna Better Health offers a TDD line for hearing-impaired members. Aetna Better Health Member Services department can establish interactions with other TDD lines and/or be available to mediate a TDD line. When a member prefers that available family or friend interpret for them or decides not to utilize Aetna Better Health' hearing impaired support service line, this preference must be noted in the member's medical record.

Regional Wellness Centers

Aetna Better Health has established Aetna Better Health Regional Wellness Centers in the state of Virginia, where members, caregivers, providers, and community organizations can meet face-to-face with care coordinators, provider relations staff, community health workers, peer supports, employment and workforce specialists, and community resource team members.

The Regional Wellness Centers are a centralized point for member events and education, provider training, member and caregiver drop-in, health fairs, volunteerism, and many other supports for the community, including Integrated Care Team meetings in order to develop and execute individual member care plans.

Additionally, community health workers will link members to safe housing, local food markets, job opportunities, and training, access to health care services, community-based resources, transportation, recreational activities, and other services and supports, such as expanded respite for caregivers.

Our Wellness Centers will be available to all members, with no limits, as well as caregivers, providers, and community organizations.

Regional Wellness Staff & Assistance

Our staff in the Aetna Better Living Regional Wellness Centers includes community health workers, who live in the local area and will help us to identify members who have gaps in care and need to see their provider. At least one dedicated regional team is located in each region, with a Regional Wellness Center Manager to coordinate staff that live in and operate within the region.

Staff within our Regional Wellness Center may include:

- Regional Wellness Center Manager
- Peer Support Specialists
- Community Health Workers (CHWs)
- Housing Specialists
- Workforce Specialists
- Recovery and Resiliency Specialists
- Practice Transformation Consultants (for Health Homes)

Staff will be available to assist members with:

- Employment through our Workforce Specialist and other staff, including helping members write resumes.
- Providing interview coaching and linking members to employers.
- Hosting GED classes and support groups for children and families affected by deportation and children of divorced parents.
- Offering educational workshops on health and wellness related topics including healthy cooking, nutrition, parenting, self-esteem for teens, and more.

- Connecting members to services and social supports through our extensive database of all available community services and support.
- Support for mental health and substance use issues through our Peer Support Specialists with similar life experiences who can relate to our members and offer practical suggestions.
- Scheduling transportation and health and life coaching in the regional wellness center.
- Housing through our Housing Specialist and other staff who link members to resources for accessible housing, utility assistance, and other resources including home modifications.
- Offering health and life coaching.
- Supporting caregivers with peer groups and workshops

The wellness centers will make available free of charge conference rooms and meeting space for community events as well as private areas for members and families who wish to meet with our Case Managers.

We will also have training areas for providers, who can also meet in person with provider relations staff if assistance is required for billing questions or issues. In addition, we will make wireless internet and printers available free of charge as well.

Our wellness centers are available to all members, with no limits, as well as to caregivers, providers, and community organizations. All members can use our wellness centers regardless of condition/need to visit wellness center.

Note: Provider services will not be offered at regional wellness centers; services offered will not replace health care services provided by PCP and other specialists.

Services for caregivers

We offer the following caregiver services at our regional wellness centers:

- Provide workshops on topics such as, "How to Take Care of Yourself While Caring for Others"
- Use of meeting space, computers, and internet services for providers/community-based organizations
- Assistance with billing, claims resolution, and other questions

Provider education

Aetna Better Health will offer training sessions for providers at our regional wellness centers where our Care Coordinators will educate them on the ways in which to better help I/DD members overcome their fears and anxieties associated with treatment and care. These sessions will enable providers to eliminate members' need for sedation or restraint, as well as to reduce their fear, resistance, and avoidance. Through a gradual, step-by-step process, (in collaboration with their family members or support system), providers receive hands-on training that enable them to move from practice to treatment, thus making routine care a success.

Chapter 7 — Member eligibility and enrollment

Member Services

Member Services provides information for members on eligibility, benefits, grievances, education, and available programs. Member advocates can provide services for members having trouble with their health care needs, finding providers, and filing grievances or appeals, as well as assist providers with noncompliant members and/or discharges.

Member Services can be reached at **800-279-1878** (Medallion and FAMIS) or **855-652-8249** (CCC Plus).

Eligibility for Medallion/FAMIS members

Eligibility determinations are made by the Commonwealth of Virginia Medicaid program prior to enrollment with a managed care plan, including Aetna Better Health. The Commonwealth of Virginia Medicaid program also determines any coverage prior to the enrollment effective date with Aetna Better Health. DMAS pays us a monthly premium for member Aetna Better Health coverage. If members are found not eligible for Aetna Better Health coverage for past months because they did not give truthful information to their case worker or tell their case worker about changes in their circumstances, they may have to pay DMAS back for these premiums even if they do not get medical services under Aetna Better Health benefits during these months.

Virginia operates a program of mandatory participation in a managed care program for the following groups of members:

- Children in foster care
- Persons under age 21 who are receiving Medicaid
- Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
- SSI members who do not receive Medicare
- Persons receiving Medicaid for the blind or disabled
- Persons receiving Medicaid for the aged
- Pregnant women

Within the groups identified above, the following groups of members are currently excluded from managed care:

- Persons who are inpatient in state mental hospitals
- Persons who are approved by the department as inpatients in long-stay hospitals
- Persons who are placed on spend-down
- Persons who are participating in Federal Waiver Programs for home-based and community-based Medicaid coverage prior to managed care enrollment. Persons enrolled in the Elderly or Disabled with Consumer Direction waiver, if determined to be Medallion managed care eligible, shall not be excluded.
- Persons other than students who permanently live outside their area of residence for greater than consecutive days, except those members placed there for medically necessary services funded by Aetna Better Health or other managed care organization.
- Persons who receive hospice services in accordance with department criteria
- Person with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents and any insurance purchased through the Health Insurance Premium Payment Program. Veteran's Affairs benefits are not considered "other insurance."
- Newly eligible members who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their enrollment becomes effective.
    - Exclusion may be granted only if the member's obstetrical provider (provider, certified nurse midwife, or hospital) does not participate with any of the state-contracted managed care organizations. Exclusion requests within this paragraph shall be made by the member, managed care organization, or obstetrical provider.
- Person under the age of 21 who are approved for DMAS residential facility level C programs

- Persons who have been assigned to Aetna Better Health but whose provider certifies a life expectancy of six months or less may request exclusion. Requests must be made during the assignment period.
- Persons who are eligible and enrolled in the Virginia Birth-Related Neurological Injury Compensation Fund, commonly known as the Birth Injury Fund.
- Persons who are inpatients in hospitals at the scheduled time of enrollment who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This does not apply to newborns unless there is a break in coverage.
- Certain persons between birth and age three certified by the department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act, who are granted an exception by the department.
- Persons who are enrolled in the Commonwealth's Title XXI SCHIP program.
- Persons who have an eligibility period that is only retroactive.

Eligibility for CCC Plus members

Members eligible for CCC Plus when they have full Medicaid benefits, and meet one of the following categories must be:

- 65 and older.
- An adult or child with a disability.
- Reside in a nursing facility.
- Receiving services through the CCC Plus home and community-based services waiver.
- Receiving services through any of the three waivers serving people with developmental disabilities (Building Independence, Family & Individual Supports, and Community Living Waivers), also known as the DD waivers.

Enrollment for Medallion/FAMIS members

Upon initial eligibility determination and during the annual enrollment period for Medicaid, members who want to be enrolled into managed care plan can contact the enrollment broker for the state of Virginia.

Enrollment for CCC Plus members

Eligible individuals must enroll in the CCC Plus program. DMAS and the CCC Plus Helpline manage the enrollment for the CCC Plus program. To participate in CCC Plus, the member must be eligible for Medicaid.

Reasons a member would not be eligible to participate in CCC Plus program:

- Lost Medicaid eligibility
- Does not meet one of the eligible categories listed above
- Enrolled in hospice under the regular fee-for-service Medicaid program prior to any CCC Plus benefit assignment.
- Enrolled in the Medicaid Health Insurance Premium Payment program
- Enrolled in Program of All-Inclusive Care for the Elderly
- Enrolled in the Medicaid Money Follows the Person Program
- Enrolled in the Alzheimer's Assisted Living Waiver
- Lives in an intermediate care facility for individuals with intellectual and developmental disabilities
- Receiving care in a psychiatric residential treatment level C facility (children under 21)

- Lives in a veteran's nursing facility
- Lives in one of these state long-term care facilities: Piedmont, Catawba, Hiram Davis, or Hancock

Verification of eligibility

Member eligibility and enrollment can and should be confirmed by utilizing one of several methods:

- Virginia Medicaid Eligibility System at **800-772-9996** or **800-884-9730** (outside of Richmond), or **804-965-9732** or **804-965-9733** for Richmond and the surrounding counties
- Provider web portal eligibility search at **www.virginiamedicaid.dmas.virginia.gov**
- Aetna Better Health Member Services at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus)

Commonwealth of Virginia-automated eligibility information

Providers may obtain Medicaid eligibility and plan assignment information for members by calling Virginia's MediCall Automated Voice Response System (toll-free numbers are available 24 hours per day, seven days a week) at **800-772-9996** or **800-884-9730** or via the online Automated Response System (ARS) accessed through the Virginia Medicaid Web portal at **www.virginiamedicaid.dmas.virginia.gov.**

How to Access Long-Term Services and Supports (LTSS)

Aetna Better Health provides coverage for LTSS, including a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs and maintain maximum independence. LTSS can help the member live in their own home or other setting of their choice and improves their quality life. Examples services include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over a long period of time, usually in homes and communities (through a home and community-based waiver), but also in nursing facilities.

Commonwealth Coordinated Care Plus Waiver

Some members may qualify for home and community-based care waiver services through the Commonwealth Coordinated Care Plus Waiver (formerly known as the Elderly or Disabled with Consumer Direction and Technology Assistance Waivers).

The Commonwealth Coordinated Care Plus (CCC Plus) Waiver is meant to allow a member who qualifies for nursing facility level of care to remain in the community with help to meet their daily needs. If determined eligible for CCC Plus Waiver services, the member may choose how to receive personal assistance services. Members have the option to receive services through an agency (known as agency directed) or may choose to serve as the employer for a personal assistance attendant (known as consumer-directed.)

CCC Plus Waiver Services may include:

- Private duty nursing services (agency directed).
- Personal care (agency or consumer-directed).
- Respite care (agency or consumer-directed).
- Adult day health care.
- Personal emergency response system (with or without medication monitoring).
- Transition coordination/services for Members transitioning to the community from a nursing facility or long stay hospital.

- Assistive technology.
- Environmental modifications.

Consumer-Directed Care

Consumer-directed care refers to personal care and respite care services provided under the CCC Plus Waiver. These are services in which the member or their family/caregiver is responsible for hiring, training, supervising, and firing of their attendant. The member will receive financial management support in the role as the employer to assist with enrolling the providers, conducting provider background checks, and paying providers.

The member's Care Coordinator will also monitor the member's care as long as they are receiving CCC Plus Waiver services to make sure the care provided is meeting the member's daily needs.

Nursing Facility Services

If a member is determined to meet the coverage criteria for nursing facility care and choose to receive long-term services and supports in a nursing facility, Aetna Better Health will provide coverage for nursing facility care. If the member has Medicare, Aetna Better Health will provide coverage for nursing facility care after the member has exhausted their Medicare covered days in the nursing facility, typically referred to as skilled nursing care.

If a member is interested in moving out of the nursing facility into the community, please have them contact their Care Coordinator.

Screening for Long Term Services and Supports

Before a member can receive long-term services and supports (LTSS) the member must be screened by a community based or hospital screening team. A screening is used to determine if a member meets the level of care criteria for LTSS.

Freedom of Choice

If a member has been approved to receive long-term services and supports, they member has the right to receive care in the setting of their choice, including:

- In the member's home.
- In another place in the community.
- In a nursing facility.

Members can choose the doctors and health professionals of their choice from the Aetna Better Health network. If they prefer to receive services in their home under the CCC Plus Waiver, for example, the member can choose to directly hire their own personal care attendant(s), known as consumer-directed care. Another option the member has, is to choose a personal care agency in our network, where the agency will hire, train, and supervise personal assistance workers on the member's behalf, known as agency direction. The member will also have the option to receive services in a nursing facility from our network of nursing facility providers.

Developmental Disability Waiver

If a member is enrolled in one of the DD waivers, the member will be enrolled in CCC Plus for their non-waiver services. The DD waivers include:

- The Building Independence (BI) Waiver,

- The Community Living (CL) Waiver, and
- The Family and Individual Supports (FIS) Waiver.

DD Waiver services, DD and ID targeted care coordination services, and transportation to/from DD waiver services, will be paid through Medicaid fee-for-service as "carved-out" services. The carve-out also includes any DD waiver services that are covered through EPSDT for DD waiver enrolled individuals under the age of 21.

If a member has a developmental disability and needs DD waiver services, the member will need to have a diagnostic and functional eligibility assessment completed by their local Community Services Board (CSB). All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in the member's person-centered individualized service plan.

The DD waivers have a wait list. Individuals who are on the DD waiver waiting list may qualify to be enrolled in the CCC Plus Waiver until a BI, CL or FIS DD waiver slot becomes available and is assigned to the individual. The DD waiver waiting list is maintained by the CSBs in the member's community. For more information on the DD Waivers and the services that are covered under each DD Waiver, visit the department of Behavioral Health and Developmental Services (DBHDS) website at: **www.mylifemycommunityvirginia.org** or call **1-844-603-9248**. A Care Coordinator will work closely with the member and the member's DD or ID case manager to help them get all of their covered services.

Non-Emergency Transportation Services

Non-Emergency Transportation Services Covered by Aetna Better Health

Non-Emergency transportation services are covered by Aetna Better Health for covered services, carved out services, and enhanced benefits.

Exception: If the member is enrolled in a DD Waiver, Aetna Better Health provides coverage for their transportation to/from the member's non-waiver services.

Transportation may be provided if the member has no other means of transportation and need to go to a provider or a health care facility for a covered service. For urgent or non-emergency medical appointments, call the reservation line at **855-652-8249**. If the member is having problems getting transportation to their appointments, call our Member Services at: **855-652-8249**.

In case of a life-threatening emergency, call **911**.

Transportation to medical appointments is a covered benefit and members must call three working days before their visit or we will not be able to guarantee a ride. We must preauthorize the service. Members may ask for medical transportation for eye, dental, behavioral health, and medical visits. Transportation is not covered for picking up prescriptions and refills at a pharmacy when drugs can be delivered or mailed. Transportation is covered if the pharmacy does not have delivery or will not mail the prescription or the prescription cannot be filled at the medical facility. **Normally the prescription should be filled initially on the return trip from the medical appointment.** Transportation may be in the form of a public or private vehicle. This transportation must be used only when the member visit is for care that is covered, and the member does not have their own transportation.

Transportation to and From DD Waiver Services

If a member is enrolled in a DD Waiver, Aetna Better Health provides coverage for transportation to and from non-waiver services. (Call the number above for transportation to non-waiver services.)

Transportation to a member's DD Waiver services is covered by the DMAS Transportation Contractor. Members can find out more about how to access transportation services through the DMAS Transportation Contractor on the website at **www.dmas.virginia.gov/Content_pgs/trn-info.aspx** or by calling the Transportation Contractor. Transportation for routine appointments are taken Monday through Friday between the hours of 6:00 AM to 8:00 PM. The DMAS Transportation Contractor is available 24 hours a day, seven days a week to schedule urgent reservations, at: **866-386-8331** (TTY: **711**) to reach a relay operator.

If a member has problems getting transportation to their DD waiver services, the member may call their DD or ID Waiver case manager or the DMAS Transportation Contractor at the number above. Members may also call their Care Coordinator. Care Coordinator's will work closely with the member and the member's DD or ID Waiver case manager to help get the services that they need.

Member patient pay towards LTSS

Members may have a patient pay responsibility towards the cost of nursing facility care and home and community-based waiver services. A patient pay is required to be calculated for all members who get nursing facility or home and community-based waiver services. When a member's income exceeds a certain amount, the member must contribute toward the cost of their long-term services and supports. If a member has a patient pay amount, they will receive notice from their local Department of Social Services with their patient pay responsibility. DMAS also shares patient pay amounts with Aetna Better Health if the member is required to pay towards the cost of their long-term services and supports.

Medicare members and Part D drugs

If a member has Medicare, members will receive prescription medicines from Medicare Part D; not from the CCC Plus Medicaid program. CCC Plus does not pay the copayment for the medicines that Medicare Part D covers.

Coverage for newborns born to moms covered under CCC Plus

Members who have a baby will need to report the birth as quickly as possible in order for the baby to be enrolled in Medicaid. Members can do this by:

- Calling the Cover Virginia Call Center at **855- 242-8282** to report the birth over the phone, or
- Contacting your local department of Social Services to report the birth.

Identification cards for Medallion/FAMIS members

Members are provided a Medicaid ID card from the Commonwealth of Virginia. Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled in the Aetna Better Health plan. An ID card will be mailed to each new member when a PCP is selected or assigned.

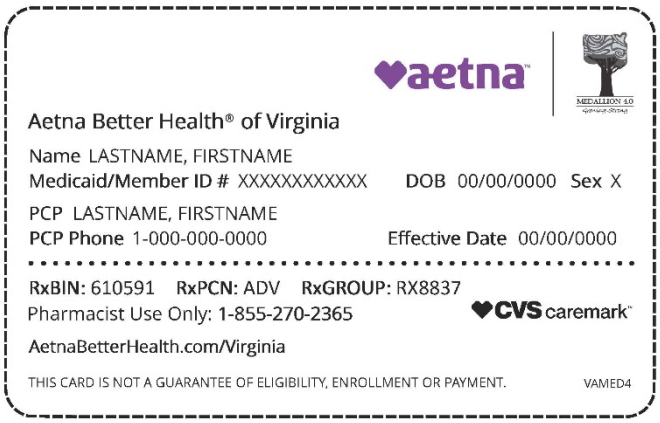
Members are encouraged to keep the identification card with them at all times. If the card is lost or stolen, the member should call Member Services immediately to get a new card. Should a member present without a card or present with a state of Virginia Medicaid ID card, services should not be denied. To confirm the Aetna Better Health member's PCP selection, call Member Services at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus).

The Aetna Better Health identification card will include the following information:

- Aetna Better Health' name
- Member name

- Member/state Medicaid ID number
- PCP name and telephone number
- Member Services telephone number
- Claim submission information
- 24-hour Informed Health Line telephone number
- Behavioral Health/Crisis telephone number

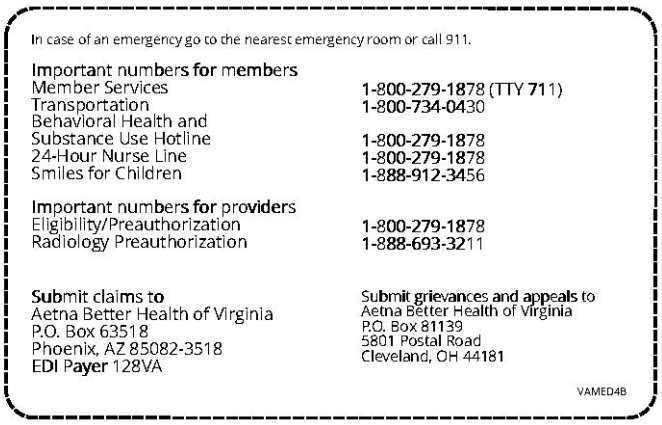
Example of Medallion ID card



There are four different member ID cards (three for Medallion and FAMIS) with product identifiers in the lower right-hand corner of each card:

1. MEVAFAMIS1—Copay No / $0
2. MEVAFAMIS2—Copay Yes / $2— (see above example)
3. MEVAFAMIS5—Copay Yes / $5
4. MEVATANF1—(Medallion) Copay Nonapplicable—(see below example)

Back information — same for all Member ID cards — see example below

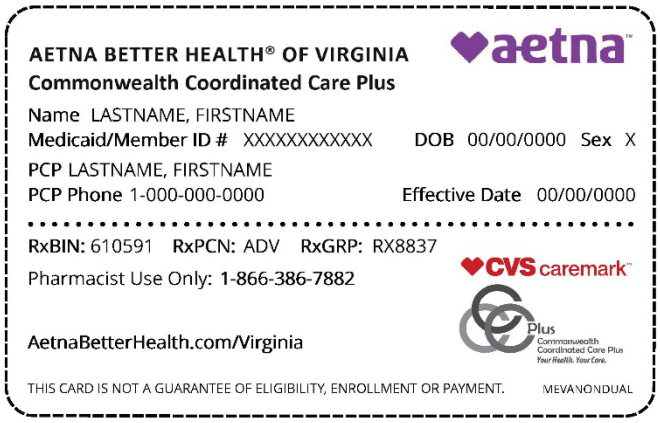


Identification cards for CCC Plus members

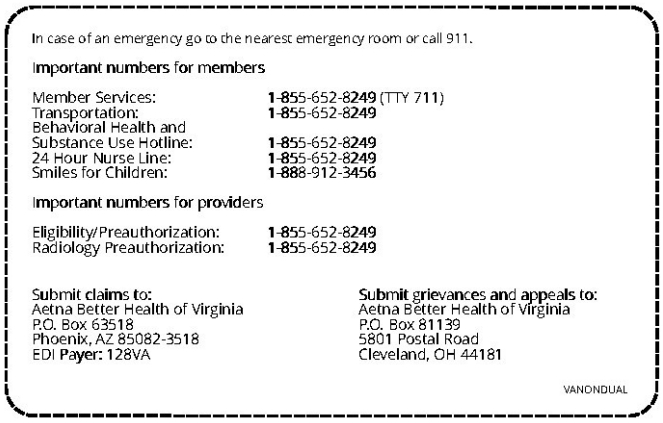
Upon enrollment into the Aetna Better Health plan, an ID card will be issued for each family member enrolled. An ID card will be mailed to each new member when a PCP is selected or assigned.

We encourage members to keep their identification card with them at all times.

Example of CCC Plus ID card (non-dual members)



AETNA BETTER HEALTH® OF VIRGINIA
Commonwealth Coordinated Care Plus
Name LASTNAME, FIRSTNAME
Medicaid/Member ID # XXXXXXXXXXX DOB 00/00/0000 Sex X
PCP LASTNAME, FIRSTNAME
PCP Phone 1-000-000-0000 Effective Date 00/00/0000
RxBIN: 610591 RxPCN: ADV RxGRP: RX8837
Pharmacist Use Only: 1-866-386-7882
AetnaBetterHealth.com/Virginia
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEVANONDUAL



In case of an emergency go to the nearest emergency room or call 911.

Important numbers for members

Member Services:	1-855-652-8249 (TTY 711)
Transportation:	1-855-652-8249
Behavioral Health and Substance Use Hotline:	1-855-652-8249
24 Hour Nurse Line:	1-855-652-8249
Smiles for Children:	1-888-912-3456

Important numbers for providers

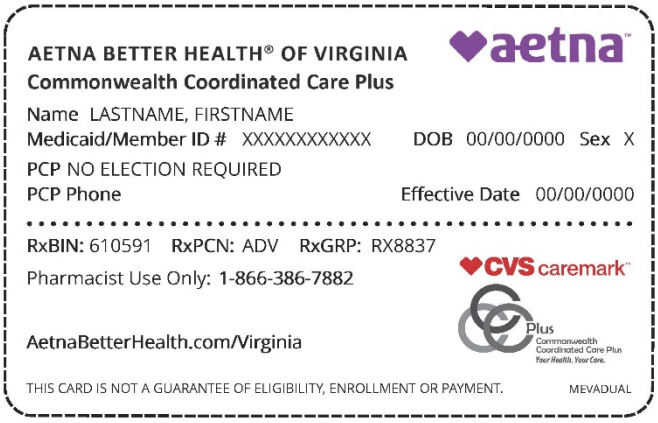
Eligibility/Preauthorization:	1-855-652-8249
Radiology Preauthorization:	1-855-652-8249

Submit claims to:
Aetna Better Health of Virginia
P.O. Box 63518
Phoenix, AZ 85082-3518
EDI Payer: 128VA

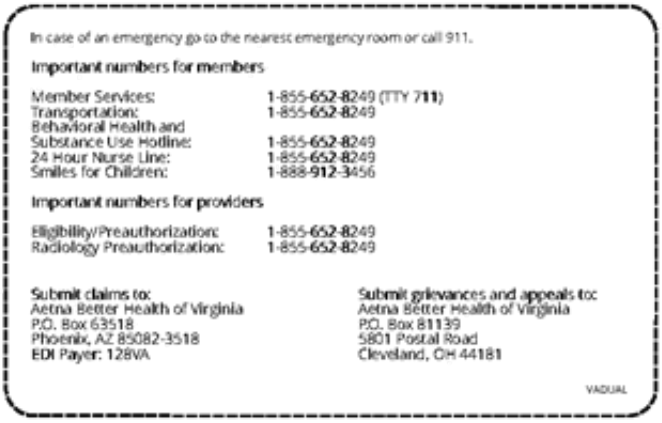
Submit grievances and appeals to:
Aetna Better Health of Virginia
P.O. Box 81139
5801 Postal Road
Cleveland, OH 44181

VANONDUAL

Example of CCC Plus ID Card (dual members)



AETNA BETTER HEALTH® OF VIRGINIA
Commonwealth Coordinated Care Plus
Name LASTNAME, FIRSTNAME
Medicaid/Member ID # XXXXXXXXXXX DOB 00/00/0000 Sex X
PCP NO ELECTION REQUIRED
PCP Phone Effective Date 00/00/0000
RxBIN: 610591 RxPCN: ADV RxGRP: RX8837
Pharmacist Use Only: 1-866-386-7882
AetnaBetterHealth.com/Virginia
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEVADUAL



In case of an emergency go to the nearest emergency room or call 911.

Important numbers for members

Member Services:	1-855-652-8249 (TTY 711)
Transportation:	1-855-652-8249
Behavioral Health and Substance Use Hotline:	1-855-652-8249
24 Hour Nurse Line:	1-855-652-8249
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Phoenix, AZ 85082-3518
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Submit grievances and appeals to:
Aetna Better Health of Virginia
P.O. Box 81139
5801 Postal Road
Cleveland, OH 44181

VADUAL

Member rights and responsibilities

Medallion/FAMIS member rights

Aetna Better Health Medallion/FAMIS members have the right to:

- Be informed of Aetna Better Health and all covered services.
- Receive information about Aetna Better Health, our services, doctors, other providers, and member rights and responsibilities.
- Be treated with respect, dignity, and the right to privacy.
- Choose their personal Aetna Better Health doctor/PCP.
- Change their Aetna Better Health PCP.
- Be treated regardless of race, gender, religion, disability, ethnicity, national origin, or source of payment.
- Expect all information about their health to be confidential and to have their privacy protected.
- Not have their medical records shown to others without their approval, unless allowed by law.
- Receive information from their doctor about treatment options or other types of care available to members, appropriate to their condition, and explained in a way that members can understand.
- Receive services from out-of-network providers.
- Receive a second opinion on a medical procedure from an in-plan provider. If an Aetna Better Health provider is not available, we will help members get a second opinion from a non-participating provider at no cost to members.
- Participate with their doctor/provider in making decisions about their health care
- Tell the doctor/provider that members do not want treatment and be told what may happen if members do not have the treatment. Members can continue to get Medicaid and medical care without any repercussions even if members say no to treatment.
- Make an official complaint or grievance about Aetna Better Health or file an appeal if members are not happy with the answer to their question, complaint/grievance, or care given.
- Appeal a medical decision made by Aetna Better Health directly to DMAS.
- Know the cost to members if members choose to get a service that Aetna Better Health does not cover.
- Be told in writing by Aetna Better Health when any of their health care services requested by their PCP are reduced, suspended, terminated, or denied. Members must follow the instructions in their notification letter.
- Have members and/or their child's doctor/provider tell members about treatment choices members may have, no matter what the cost or benefit coverage.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Find out what is in their medical records and request that they be corrected or amended.
- Request a copy of their medical records.
- Exercise their rights and to know that members will not have any retaliation against members by Aetna Better Health, any of our doctors/providers or state agencies.
- Access to health care services and medical advice 24 hours a day, seven days a week, including urgent and emergency services.
- Get family planning services from any participating Medicaid provider without prior authorization.
- Get information in different formats (i.e., large print, Braille, etc.), at no cost to members, if needed and in an easy form that takes into consideration the special needs of those who may have problems seeing or reading.

- Get interpretation services if members do not speak English or have a hearing impairment to help members get the medical services members need.
- Make recommendations or suggestions regarding Aetna Better Health's member rights and responsibilities.
- Develop Advance Directives or a Living Will, which tell how to have medical decisions made for members if members are not able to make them for themselves.
- Ask for a description of all types of payment arrangements that we use to pay providers for health care services.

CCC Plus member rights

Aetna Better Health CCC Plus members have the right to:

Members have the right to:

- Receive timely access to care and services.
- Take part in decisions about their health care, including their right to choose their providers from Aetna Better Health network providers and their right to refuse treatment.
- Choose to receive long-term services and supports in their home or community or in a nursing facility.
- Confidentiality and privacy about their medical records and when member gets treatment.
- Receive information and to discuss available treatment options and alternatives presented in a manner and language member understands.
- Get information in a language member understands; member can get oral translation services free of charge.
- Receive reasonable accommodations to ensure member can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services.
- Receive information necessary for member to give informed consent before the start of treatment.
- Be treated with respect and dignity.
- Get a copy of their medical records and ask that the records be amended or corrected.
- Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to member or others, or when there is a specific medical necessity. Seclusion and restraint will never be used as a means of coercion, discipline, retaliation, or convenience,
- Get care without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status, or religion.
- Be informed of where, when, and how to obtain the services member need from Aetna Better Health, including how member can receive benefits from out-of-network providers if the services are not available in Aetna Better Health's network.
- Complain about Aetna Better Health to the State. Member can call the CCC Plus Helpline at **1-844-374-9159** or TDD **1-800-817-6608** to make a complaint about us.
- Appoint someone to speak for member about their care and treatment and to represent member in an appeal.
- Make advance directives and plans about their care in the instance that member is not able to make their own health care decisions. See Section 17 of their member handbook for information about Advance Directives.
- Change their CCC Plus health plan once a year for any reason during open enrollment or change their MCO after open enrollment for an approved reason. Reference Section 2 of their member

handbook or call the CCC Plus Helpline **at 1-844-374-9159** or TDD **1-800-817-6608** or visit the website at **cccplusva.com** for more information.
- Appeal any adverse benefit determination (decision) by Aetna Better Health that member disagrees with that relates to coverage or payment of services.
- File a complaint about any concerns that member has with our customer service, the services member has received, or the care and treatment member has received from one of our network providers. See Their Right to File a Complaint in Section 15 of their member handbook.
- To receive information from us about our plan, their covered services, providers in our network, and about their rights and responsibilities.
- To make recommendations regarding our member rights and responsibility policy, for example, by joining our Member Advisory Committee.

Right to be Safe

Everyone has the right to live a safe life in the home or setting of their choice. Each year, many older adults and younger adults who are disabled are victims of mistreatment by family members, by caregivers and by others responsible for their well-being. If a member is being abused, physically, is being neglected, or is being taken advantage of financially by a family member or someone else, a member should call their local department of social services or the Virginia Department of Social Services' 24-hour toll-free hotline at: **888-832-3858**. Members can make this call anonymously; they do not have to provide their name and the call is free.

Trained local workers may be provided to assist and help the member receive the types of services they need to assure that they are safe.

Right to Confidentiality

Aetna Better Health will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse.

Aetna Better Health staff will ask questions to confirm the member's identity before we discuss or provide any information regarding their health information.

We understand the importance of keeping personal and health information secure and private. Both Aetna Better Health and the member's doctors make sure that all member records are kept safe and private. We limit access to personal information to those who need it. We maintain safeguards to protect it. For example, we protect access to our buildings and computer systems. Our privacy office also assures the training of our staff on our privacy and security policies. If needed, we may use and share personal information for treatment, payment, and health care operations. We limit the amount of information that we share about members as required by law. For example, HIV/AIDS, substance abuse and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

Member responsibilities:

Aetna Better Health members are responsible for:

- Reading the member handbook.
- Scheduling wellness check-ups. Members under 21 years of age need to follow the EPSDT schedule.
- Getting care as soon as members know they are pregnant.

- Keeping all prenatal appointments.
- Carrying and showing Aetna Better Health ID card to each doctor before getting health services.
- Protecting member ID card and not sharing it with others.
- Getting medical care from providers in our network.
- Knowing the name of member's assigned PCP.
- Telling the doctor that the member and/or their child or children is/are a member of Aetna Better Health at the time that they speak with the doctor's office.
- Keeping doctor's appointments or calling to cancel them at least 24 hours ahead of time.
- Using the ER for true emergencies only.
- Learning the difference between emergencies and when urgent care.
- Treating the doctors/providers, staff and people providing services with respect.
- Giving all information about member's health to Aetna Better Health and member's doctor in order to provide care,
- Telling the doctor if member does not understand what they tell member about member's health so that the member and doctor can make health plans together.
- Following what member and doctor agree to do including making follow-up appointments, taking medicines and following the doctor's care instructions.
- Telling Aetna Better Health and DMAS when member's address changes.
- Telling Aetna Better Health about changes in member's family that might affect member's eligibility or enrollment such as family size, employment, and moving out of the state of Virginia.
- Telling Aetna Better Health if member has other health insurance, including Medicare.
- Giving member's doctor a copy of their Living Will and/or Advance Directive.
- Learning about prescription drugs and reasons for taking them.
- Letting Aetna Better Health know how we can work better for the member.

Aetna Better Health distributes its member rights and responsibility statement to new members in enrollment kits and to existing members via newsletter and website access each year. Members can request a copy be mailed to them by contacting Member Services. We also distribute the member rights and responsibility statement to new providers when they join our network and to existing providers each year via the website.
In addition, Aetna Better Health complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

Persons with special health care needs

The health plan is required to do the following for members identified as persons with special health care needs:

- Conduct an assessment in order to identify any special conditions of the member that require ongoing care management services
- Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs
- For individuals determined to require care management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the member

PCP assignment

Each Aetna Better Health member is assigned a PCP. Members are allowed to select a PCP at the time of enrollment and may change their PCP voluntarily at any time by contacting Member Services. For involuntary termination of a PCP, please see Noncompliant members/PCP Transfer in Provider Responsibilities and Important Information chapter.

PCP selection

PCPs include providers in the following specialties:

- Family practice
- General practice
- Internal medicine
- Pediatrics
- Obstetrics/gynecology
- Certified nurse practitioners (under direct supervision of a provider)
- Certified nurse midwife (under the supervision of a provider)

Every family member enrolled in the plan must choose a PCP, although it does not have to be the same provider. All members have the option of changing their PCP. Members may request to change their PCP following the initial visit without cause. PCP change requests made before the 15th of the month are made effective the first of the same month. PCP change requests made after the 15th of the month are made effective the first of the next month (i.e., request received October 15 effective November 1).

- Aetna Better Health members are given the opportunity to select a PCP.
- If a member has NOT selected a PCP upon enrollment, Aetna Better Health shall assign one for them. Aetna Better Health shall consider factors such as age, gender, language(s) spoken, location, and special needs.
- Upon notice of the current automatically assigned PCP by Aetna Better Health, the member has the opportunity to request a PCP change if not satisfied with the assigned PCP.
- A list of PCPs is made available to all Aetna Better Health members. Member Service representatives are available to assist members with selecting a PCP.
- Members have the freedom to select participating PCPs based on age/gender limit restrictions.
- Members are encouraged to choose a PCP that is geographically convenient to them; however, members are not restricted by any geographic location.

Aetna Better Health members may change their PCP at any time, by contacting Member Services at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus).

Members with a disabling condition and/or chronic illness may request that their PCP be a specialist. These requests will be reviewed by the Aetna Better Health Medical Director to ensure that the specialist requested agrees to accept the role of PCP and assume all the responsibilities associated with this role. Members need to contact Member Services directly for such requests. Member Services will route the request directly to the Medical Director for review.

Aetna Better Health may initiate a change in a member's PCP under the following circumstances:

- The member's PCP ceases to participate in Aetna Better Health's network.
- The provider/patient relationship will not work to the satisfaction of either the provider or the patient.

- The provider requests the patient select another PCP and sends written notification to the member and to Aetna Better Health, giving a minimum of 30-days' notice.

Members are advised to get to know and maintain a relationship with their PCP. They are instructed to always contact their PCP before obtaining specialty services or going to the emergency room. It is the responsibility of all PCPs to manage the care of each patient, directing the patient to specialty care services as necessary. It is the responsibility of the specialist provider to work closely with the PCP in the process.

Newborn enrollment

Newborns of eligible Aetna Better Health members will be automatically enrolled into Aetna Better Health, by the Medical Service Administration. Unless the mother selects a different Medicaid Managed Care Plan, newborns born during the mother's Aetna Better Health enrollment are eligible to receive services from Aetna Better Health.

Hospital social service coordinators or local caseworkers usually initiate the process of educating and facilitating the mother of an Aetna Better Health newborn to complete the Medicaid enrollment process. To notify Virginia Medicaid or

FAMIS of the child's birth, a Newborn Eligibility Notification form (DMAS 213) will be submitted to Virginia Medicaid or FAMIS by Aetna Better Health's Enrollment department. Participating Providers and Hospitals are encouraged to submit newborns via the streamlined online enrollment process through the Medicaid provider web portal at https://www.virginiamedicaid.dmas.virginia.gov/.

Newborns are retrospectively enrolled with Aetna Better Health back to the date of birth by the state. Delayed newborn enrollment may cause a delay in claim reimbursement for Providers. Once the file is received from the state with the newborn enrolled, your claim will be processed.

If the mother has not selected a PCP for her newborn, Aetna Better Health shall make the PCP assignment once the newborn has been individually enrolled as an Aetna Better Health member.

Member removal from PCP panel

The PCP may request removal of a member from their panel upon submission of supporting documentation verifying circumstances that warrant removal. Circumstances that may warrant a disenrollment request include, but are not limited to:

- Failure to follow a recommended health care treatment plan. (This can occur after one verbal or one written warning of the implication and possible effect of noncompliance.)
- Documented chronic missed appointments.
- Documented behavior, which is consistently disruptive, unruly, abusive, or uncooperative.
- Documented behavior which constitutes a threat or danger to the office staff or other patients.

To remove a member from their panel, PCPs should:

- Notify the member in writing to choose another PCP and of the reason for termination with 30 days' notice and by certified mail.
- Manage care for emergent services during this time period.
- Fax termination notification with supporting documentation to the Provider Relations department. The fax number is **844-230-8829**.

Provider Relations department will review the notification to determine whether the termination needs to be addressed for care management intervention or be forwarded to the Compliance department for direct action with DMAS.

Member disenrollment from Aetna Better Health

DMAS has sole authority for dis-enrolling members. DMAS may disenroll members for any of the following reasons:

- Loss of eligibility
- Placement of the member in a long-term nursing facility, state institution or intermediate care facility for individuals with intellectual disabilities for more than thirty days
- Member selection of a different Medicaid Managed Care Plan
- Member change of residence outside of the Aetna Better Health service area
- Profound noncompliance of a member to follow prescribed treatments or requirements that are consistent with state and federal laws and regulations when agreed upon by the DMAS
- Abuse of the system, threatening or abusive conduct/behavior that is disruptive and unruly which seriously impairs Aetna Better Health ability to provide service to either the member or others
- Commitment of intentional acts to defraud Aetna Better Health and/or DMAS for covered services

Violent or life-threatening behavior

The provider must provide written notification that a member has demonstrated one or more of the above behaviors, in addition to the following supportive documentation as appropriate:

- Police report and or incident report from staff involved or threatened
- Copy of member's chart documenting member was previously counseled on the behavior by the PCP (if applicable)
- Any other documentation to support request for disenrollment

Fraud or misrepresentation

Medicaid fraud carried out by members may include the following:

- Lying or holding back information when signing up to be a member of Virginia Medicaid or FAMIS
- Letting someone else use the member's Aetna Better Health Member ID card
- Not telling the Social Security Administration or the Department for Community Based Services about changes in income and family status
- Not telling Virginia Medicaid that the member has other insurance

For cases of fraud or misrepresentation:

- Police report, or if no police report:
  - Documentation as to why it was not reported
  - Documentation that indicates the case was referred to the Commonwealth of Virginia's Office of the State Inspector General, phone: **804-625-3255**, fax: **804-786-2341**, email: **osig@osig.virginia.gov**
- Incident report on the fraudulent activity
- Copies of altered prescription and/or copies of original prescription
- Copy of patient signature log from the pharmacy, along with the pharmacy profile
- Copies of any member correspondence (i.e., PCP dismissal letter to the member, letter from Aetna Better Health to the member, explaining our policies, etc.)

- Additional documentation to support request for disenrollment, especially if there is no police report to show patterns of past questionable behaviors involving drugs, changing doctors, etc.

Member education - New member Information

Educational and informational materials are frequently sent to our members. Aetna Better Health members are sent a welcome packet upon enrollment. The welcome packet contains the following:

- Welcome newsletter
- List of covered drugs (formulary)
- Instructions to access the online Provider Directory
- Addiction and Recovery Treatment Services (ARTS) informational letter
- Notice of privacy practices that contains Aetna Better Health protocols relative to ensuring member privacy of records

Member identification cards are sent separately via first class mail service prior to the mailing of a new member welcome packet. Aetna Better Health identification cards indicate the PCP's name and telephone number.

Medicaid members must sign a Medical Release of Information Form when they enroll with the Virginia Medicaid Program. This release authorizes the release of medical records to Aetna Better Health and any representative of Aetna Better Health to promote:

- Continuity of care.
- Assist in the coordination of care.
- Clinical review.
- State and federal sponsored audit.
- Accreditation.

Member outreach activities

The Aetna Better Health Member Outreach department and Quality Management department are responsible for contacting members to assist with coordinating gaps in care. The Member Outreach department frequently coordinates activities within the community to provide member education and information regarding Aetna Better Health member initiatives.

Advanced directives

Please see the Provider Responsibilities and Important Information chapter for additional information.

Member grievance and appeal process

Members have the right to file a complaint (grievance) or dispute an adverse determination (appeal). The health plan asks that all providers cooperate and comply with all Aetna, Medicaid, and/or CMS requirements regarding the processing of member complaints and appeals, including the obligation to provide information within the timeframe reasonably requested for such purpose. For further guidance on the member grievance and appeal process, please contact Member Services.

Member appeals mailing address:

Aetna Better Health of Virginia
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Member handbook

A member handbook is available upon request. Changes to any program or any service site changes are provided to members in a timely manner. The member handbook includes information about covered and noncovered services and covers key topics such as how to choose and change a PCP, copays, and guidance to emergency care. The member handbook is available electronically on the Aetna Better Health website.

Chapter 8 - Care Management

The purpose of Care Management is to identify, assess, and provide intervention in cases that due to their chronicity, severity, complexity, and/or cost, require close management to affect an optimal member outcome in a cost-effective manner. The Care Manager will review medical management/Utilization Management data such as, but not limited to, specific high-risk diagnosis, multiple admissions, or ER visits length of stay admissions greater than seven days, and/or multiple disciplines/therapies required for a treatment.

Providers, nurses, and plan staff work together to identify those who may benefit from care management. Aetna Better Health identifies members by several means, including health risk assessments and data screening. We may receive a referral from a health information line nurse, chronic condition management program staff, discharge planner or other UM staff. Referrals can also be made by members and their families or caregivers. All members have access to a Care Manager. Care managers typically are registered nurses or social workers. The Care Manager works with you, the member, caregiver and/or family to come up with a plan of care that meets the member's needs. The amount help that a member receives depends on the individual.

If you have a member who has a chronic condition, you or your staff can make a referral to Aetna Better Health's chronic condition management program at any time. To make a referral or to find out more information call Member Services and ask for the Integrated Care Management department. Additional information and instructions regarding how to use chronic condition management services are available on our website under For Members then clicking Special Programs then Disease Management tabs.

The Care Manager requests information to assess the member's current medical status, treatment plan, and potential medical treatment requirements and identify those non-medical issues that may impact the member's medical outcome. The Care Manager will collaborate with specialty consultants, attending provider, the PCP, the member, the member's "family," and other members of the health care team in order to facilitate the highest quality of service, at the most cost effective level, that support the goals established to achieve the member's best long term outcome.

The Care Manager will attempt to identify and direct the use of alternative resources within the community that serve to support achieving established goals in the event a benefit is not available.

The Care Manager serves as a liaison for Providers, members, family, and/or alternate payers to insure compliance to the treatment plan, facilitate the appropriate use of cost effective alternative services, as well as assess effectiveness of the treatment plan based on goals achieved.

Cases will be considered closed upon the termination of the member, refusal of the member or family to participate with the care coordination process; and/or if the provider and/or member agree that the reassessment, current treatment plan and/or progress of the member is such that care coordination intervention is no longer required to maintain the member at his/her optimum level of wellness. To request an evaluation for complex care management support, providers may contact Aetna Better Health at **800-**

279-1878 or AetnaBetterHealthVA-CaseManagement@AETNA.com (Medallion and FAMIS), or **855-652-8249** (CCC Plus).

Aetna Better Health implements a population-based approach to specific chronic diseases or conditions. All Aetna Better Health members with identified conditions are auto enrolled in the program based on claims date. Members that do not wish to participate can call member services and notify the Plan of their desire not to participate and they will be disenrolled from the program. All members are sent educational material to promote better member understanding of the disease or condition affecting them. Information also addresses self-care, appropriate medical care, and testing which are supported by evidence-based practices and tools. Additionally, auto alert flags to the Care Manager's desktop identifying members with significant "gaps" in their care and/or disease/condition education. Care managers reach out to those members in an effort to educate and assist the members in obtaining needed services including lifestyle modifications and health resource access.

Our goal is to assist our members/your patients, to better understand their chronic conditions, update them with new information and provide them with assistance from our staff to help them manage their disease. Providers can contact the Plan at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus), and follow the prompts to enroll a member in our Care Management program.

The following services are offered by the program:

- Support from health plan nurses and other health care staff to ensure that patients understand how to best manage their condition and periodically evaluate their health status
- Assist foster care members, their foster care parents and legal guardians to ensure they receive the services needed and provide support to best manage any issues.
- Support high risk maternity members to assist in preventing complications or pre-term births. Periodic newsletters to keep them informed of the latest information on conditions and their management
- Educational and informational materials that assist patients in understanding and managing medications prescribed by providers, how to effectively plan for visits to see providers and reminders as to when those visits should occur

Membership in our Medallion care management program is voluntary, which means at any time members can request withdrawal from the program, they need only call the health plan's Member Services department.

Medallion 4.0 Care Coordinators

For Medallion 4.0 members, Aetna Better Health contracts with doctors, specialists, hospitals, pharmacies, and other providers. Medallion 4.0 members have the option to enroll into case management and have a dedicated care coordinator. All foster care members, adoption assistance members, early intervention members and high-risk maternity members will be assigned a care coordinator who will check-in to assess for needs. The care coordinator will work closely with the member and their provider to understand and meet their needs, connect them to necessary resources and provide information about their covered services and choices available to them.

Members can opt-in to have a dedicated Care Coordinator who will be able to help the member understand our covered services and how to access these services when needed. Their Care Coordinator will also work with the member's doctor and other health care professionals (such as nurses and physical therapists), to provide a health risk assessment, and develop a care plan that considers the needs and preferences of the member.

How a Medallion 4.0 Care Coordinator Help You

The member's Care Coordinator serves a single point of contact for the member and will assess, arrange, and monitor all care services provided by other care providers. The Care Coordinator will work closely with the member to manage their care.

Care Coordinators can:

- Provide the member assistance with appointment scheduling.
- Answer questions about getting any of the services the member may need. For example: behavioral health services, transportation, and services by other specialists.
- Help with arranging transportation for member appointments when necessary.
- Assist with setting up interpreter services.
- Answer questions the member may have about their daily health care and living needs including these services:
    - Personal care services
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Home health care
    - Behavioral health services
    - Services to treat addiction
    - Other services

For foster care and adoption assistance members, the care coordinator can assist with finding providers, provide education, assist with transitioning out of foster care when they are approaching 18, provide resources, assist in managing conditions, and monitor for additional needs.

For members receiving early intervention services, the care coordinator will be a direct point of contact for the providers and members to assist with any needs that the member may have. The care coordinator is a liaison for the early intervention providers who will help the provider so that the member receives the services needed.

CCC Plus Care Coordinators

The Commonwealth Coordinated Care Plus (CCC Plus) program is a Medicaid managed care program through DMAS. Aetna Better Health was approved by DMAS to provide care coordination and health care services. Our goal is to help members improve their quality of care and quality of life.

For CCC Plus members, Aetna Better Health contracts with doctors, specialists, hospitals, pharmacies, and other providers. These providers make up our provider network. CCC Plus members will have a dedicated Care Coordinator who will work closely with the member and the member's providers to understand and meet their needs. The Care Coordinator will also provide the member with information about their covered services and the choices that are available to them.

The members dedicated Care Coordinator will be able to help the member understand our covered services and how to access these services when needed. Their Care Coordinator will also work with the member's doctor and other health care professionals (such as nurses and physical therapists), to provide a health risk assessment, and develop a care plan that considers the needs and preferences of the member.

Care Coordination is required for CCC Plus members. The advantages of the CCC Plus care coordination include:

- Members will have a care team, which may include doctors, nurses, counselors, or other health professionals who are there to help the member receive the care they need.
- Members will have a Care Coordinator who will work with the member and their providers to make certain they receive the care they need.
- Members will be able to direct their own care with help from their care team and Care Coordinator.
- The care team and Care Coordinator will work with the member to come up with a care plan specifically designed to meet their health and/or long-term support needs. The care team will be in charge of coordinating the services the member needs. This means, for example:
    - The care team will make certain the members doctors know about all medicines the member takes so they can reduce any side effects.
    - The care team will make certain the members test results are shared with all doctors and other providers working with the member so they can be kept informed of the members health status and needs.
- Treatment choices that include preventive, rehabilitative, and community-based care.
- An on-call nurse or other licensed staff is available 24 hours per day, 7 days per week to answer member questions.

How a CCC Plus Care Coordinator Can Help

The member's Care Coordinator serves a single point of contact for the member and will assess, arrange, and monitor all care services provided by other care providers. The Care Coordinator will work closely with the member to manage their care.

Care Coordinators can:

- Provide the member assistance with appointment scheduling.
- Answer questions about getting any of the services the member may need. For example: behavioral health services, transportation, and long-term services and supports (LTSS)
    - LTSS are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance, improve the quality of their lives, and facilitate maximum independence.
    - Examples include personal assistance services (assistance with bathing, dressing, and other basic activities of daily life and self-care), as well as support for everyday tasks, such as meal preparation, laundry, and shopping.
    - LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities.
- Help with arranging transportation for member appointments when necessary.
- Answer questions the member may have about their daily health care and living needs including these services:
    - Skilled nursing care
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Home health care

- Personal care services
- Behavioral health services
- Services to treat addiction
- Housing assistance
- Other services

What is a Health Risk Assessment?

This assessment is completed for both Medallion 4.0 and CCC Plus members. Within the first few weeks after the member is enroll with Aetna Better Health, their Care Coordinator will meet with them to ask questions about their health, needs, and choices. The Care Coordinator will talk with the member about any medical, behavioral, physical, and social service needs that they may have. This meeting may be in-person or by phone and is known as a health risk assessment (HRA). An HRA is a complete assessment of the member's medical, behavioral, social, emotional, and functional status. The HRA is generally completed by the member's Care Coordinator within the first 30 to 60 days of their enrollment with us depending upon the type of services that they require. This health risk assessment will enable the member's Care Coordinator to understand their needs and help them receive the care they need.

What is a Care Plan?

Members in Medallion 4.0 and CCC Plus who are engaged and/or enrolled in case management will have a care plan. A care plan includes the types of health services that are needed for a member and how to obtain them. The care plan is developed based on the member's health risk assessment. After health risk assessment is complete, the care team will meet with the member to discuss health and/or long-term services and supports they may need and want as well as their goals and preferences. Together, the member and their care team will make a personalized care plan, specific to their needs.

How do I Refer a Member to Case Management?

For Medallion 4.0 and FAMIS:

- Providers can contact the Plan at **800-279-1878** and follow the prompts to enroll a member in our care management program **or**
- Send an Email: AetnaBetterHealthVA-CaseManagement@aetna.com with the members information and the reason for referral
- For early intervention, the provider may send an email to: EarlyInterventionServices@aetna.com

For CCC Plus:

Providers can contact the Plan at **855-652-8249** (CCC Plus) and follow the prompts to enroll a member in our Care Management program.

Chapter 9 — Pharmacy

The Aetna Better Health pharmacy benefit covers medically necessary prescription products for self-administration in an outpatient setting. The pharmacy benefit provides FDA approved outpatient prescription medications that are clinically proven to be safe and effective. Providers are encouraged to refer to the formulary when selecting prescription drug therapy for eligible members.

Aetna Better Health requires that prescribers have valid and active NPI. Prescriptions from prescribers who do not have both of these numbers will reject at the point of sale.

Aetna Better Health covers prescription medications and certain over-the-counter medicines when you write a prescription for members enrolled in Virginia Medicaid managed care. We partner with CVS Health, our Pharmacy Benefit Manager, in the administration of the pharmacy benefits.

Aetna Better Health members must have their prescriptions filled at an in-network pharmacy.

Prescriptions, drug formulary and specialty injectables

Aetna Better Health has a preferred drug list located at **AetnaBetterHealth.com/Virginia**. This preferred drug list is also available by calling the member services phone number as listed on the back of the member's card or by contacting your provider relations representative.

When possible, it is requested that a drug from the preferred list be selected for the members use. The adoption of using a preferred drug or generic medications will provide the prescriber a smooth process to allow the member to receive medications without call backs and delays at the pharmacy.

This list of preferred medications is update at least annually. It may be updated more often, to view the most update list of covered drugs you can our on-line search located at **AetnaBetterHealth.com/Virginia** and/or you can download the preferred drug list from the health plan website**.**

Nonpreferred medications are also available through our prior authorization process. Nonpreferred medications may require step therapy as well as supportive documentation showing the benefit of the drug to the member. To request coverage of a nonpreferred drug, you need to provide information to support an exception request by submitting a *Pharmacy Prior Authorization Request Form*. Some drugs or drug classes may have specific prior authorization request forms, so please visit our site to determine if a specific prior authorization form is needed. Please also include any supporting medical records that will assist with the review of the prior authorization request. *Pharmacy Prior Authorization Request Forms* are available on our website and requests may be made telephonically: **800-279-1878** (Medallion/FAMIS), or **855-652-8249** (CCC Plus), or fax: **855-799-2553**.

Electronic prior authorization (ePA) is also readily available. Requests may be submitted free of charge through CoverMyMeds® (**www.covermymeds.com/main**) or SureScripts (**www.surescripts.com/enhance-prescribing/prior authorization**).

A selection of OTC medications is available to the member. Members must have a prescription from their prescriber in order for their drug benefit to apply. OTC medications are limited to a 30-day supply.

How can you find a drug on the Formulary?

There are three ways to find a drug at **AetnaBetterHealth.com/Virginia**:

- You can search alphabetically.
- You can search by brand and generic name.
- You can search by therapeutic class.

Prior authorization process

Aetna Better Health's pharmacy prior authorization processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate. Our pharmacy prior authorization process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain prior authorization prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs
- Prescriptions that do not conform to Aetna Better Health's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)

Aetna Better Health's Pharmacy team and medical directors are responsible for adverse decisions, including a complete denial or approval of a different medication. Using specific, evidence-based prior authorization pharmacy review guidelines, Aetna Better Health require additional information prior to deciding as to the medical necessity of the drug requested, such as when:

- Formulary alternatives that have been tried and failed or cannot be tolerated (i.e., step therapy).
- There are no therapeutic alternatives listed on the formulary.
- There is no clinical evidence that the proposed treatment is contraindicated (i.e., correctly indicated as established by the FDA or as accepted by established drug compendia).

The prescribing provider and member will be appropriately notified of all decisions in accordance with regulatory requirements. Prior to making a final decision, our Pharmacy team or Medical Director may contact the prescriber to discuss the case or consult with a board-certified provider from an appropriate specialty area, such as a psychiatrist.

Aetna Better Health will offer a72-hour supply if the member's prescription has not been filled due to a pending prior authorization decision and the pharmacist believes that the Member's health would be compromised without the drug.

Step therapy

The step therapy program requires certain first-line drugs, such as generic drugs or formulary brand drugs, to be prescribed prior to approval of specific second-line drugs. Drugs having step therapy are identified on the formulary with "ST." Certain drugs on the Aetna Better Health formulary have quantity limits and are identified on the formulary with "QL."

Quantity level limits

Aetna Better Health applies quantity limits on medications to ensure safety, promote cost-effective dosing and deter waste and abuse. Quantity limits are reviewed and set based on the FDA-approved dosing and medically accepted uses. For example, medications FDA-approved for once daily administration are typically limited to one dose per day. Some medications may also be limited at a specified quantity per fill.

If you have any additional questions or comments about this or other pharmacy benefits, please feel free to contact the Pharmacy department at **800-279-1878** (Medallion and FAMIS) or **855-652-8249** (CCC Plus).

To obtain prior authorization, please call our Pharmacy Prior Authorization department at **800-279-1878** (Medallion and FAMIS) or **855-652-8249** (CCC Plus), or fax the request to **855-799-2553**. ePA can also be used by submitting prior authorization requests through CoverMyMeds® (**www.covermymeds.com/main**) or SureScripts (**www.surescripts.com/enhance-prescribing/prior authorization**).

Noncovered drugs

The following is a listing of noncovered drugs:

- Drugs that are not medically necessary.

- Drugs prescribed mainly for a cosmetic purpose. This includes Retin-A when used for any purposes other than treatment for severe acne and agents used to treat baldness.
- Experimental and investigational medication, drugs with no approved FDA indications, drugs prescribed for purposes other than the FDA-approved use, unless a drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or other peer-reviewed medical literature. Cancer drugs that are FDA approved for a certain cancer type may be used for treatment of other types of cancer provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
- OTC medications are excluded (except for those specifically on the formulary).
- Any drug marketed by a company (or labeler) that does not participate in the Fee-For-Service Medicaid Drug Rebate program in accordance with Section 1927 of the Social Security Act, 42 U.S.C.A 139r-8.
- Any product designated by the FDA as a Drug Efficacy Study Implementation drug.
- Drugs for the treatment of sexual or erectile dysfunction. Amendments to Title XIX of the Social Security Act prohibit Federal Financial Participation under Medicaid for these drugs when used to treat sexual or erectile dysfunction.
- Drugs used to promote fertility, anorexia, or weight gain.
- Any legend drug marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program.

CVS Caremark Specialty Pharmacy

CVS Caremark Specialty Pharmacy is a pharmacy that offers medications for a variety of conditions, such as cancer, hemophilia, immune deficiency, multiple sclerosis, and rheumatoid arthritis, which maynot be available at local pharmacies. Specialty medications may require prior authorization before they can be filled and delivered. Providers can call **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus) to request prior authorization or complete the applicable prior authorization form and fax to **855-799-2553**. Specialty medications can be delivered to the provider's office, member's home, or other location as requested. Other specialty pharmacies are included in our network, visit our website to determine what other pharmacies are in our network.

CVS Caremark Specialty can be reached at 800-237-2767 if needed.

Mail order prescriptions (FAMIS and CCC Plus only)

Aetna Better Health offers mail order prescription services through CVS Caremark. FAMIS and CCC Plus members can access this service in one of three ways.

- By calling CVS Caremark toll-free at **855-271-6603**/TDD **800-231-4403**, Monday through Friday from 8 a.m. to 8 p.m., EST. They will help the member sign up for mail order service. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By going to: **www.caremark.com**, FAMIS members can log in and sign up for Mail Service online. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
- By requesting their provider to write a prescription for a 90-day supply with up to one year of refills. Then the member calls CVS Caremark and asks CVS Caremark to mail them a mail service order form. When the member receives the form, the member fills it out and mails CVS Caremark the prescription and the order form. Forms should be mailed to:

  CVS Caremark
  PO Box 2110

Pittsburgh, PA 15230-2110

Chapter 10 — Concurrent review

Aetna Better Health conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. Providers must notify Aetna Better Health within 24 hours of an emergent/urgent admission. All other admissions must be prior authorized for lower levels of care. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Hearst Corporation's MCG evidence-based care guidelines (formerly Milliman Care Guidelines). Admission certification is normally conducted within 1-2 business day of receiving medical information but no later than three days of notification.

Continued stay reviews are conducted before the expiration of the assigned length of stay. Providers will be notified of approval or denial of additional days. The nurses work with the medical directors in reviewing medical record documentation for hospitalized members.

Medical criteria

To support inpatient concurrent review decisions, Aetna Better Health uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Concurrent review staff that make medical necessity determinations is trained on the criteria. These criteria are established and reviewed according to Aetna Better Health policies and procedures.

Criteria sets are reviewed annually for appropriateness to the Aetna Better Health's population needs and updated as applicable when national guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The Aetna Clinical Policy Council reviews clinical policy bulletins. The criteria are consistently applied, considering individual needs of the members and allow for consultations with requesting providers when appropriate. These are to be consulted in the order listed. For inpatient medical care reviews, Aetna Better Health uses the following medical review criteria:

- MCG for physical and behavioral health criteria
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- Aetna Clinical Policy Bulletins
- American Society of Addiction Medicine
- Criteria required by applicable state or federal regulatory agency

The guidelines span the continuum of member care and describe best practices for treating common conditions. These guidelines are updated regularly as each new version is published. A free copy of individual guidelines pertaining to a specific case is available for review upon request by phone **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus). Inpatient clinical information can be faxed to **877-817-3707** for concurrent review.

Discharge planning coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending provider are responsible for developing a discharge plan for the member and for involving the member and family in implementing the plan.

Our Concurrent Review Nurse works with the hospital discharge team and attending providers to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating of discharge planning for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending provider with names of network providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers).
- Informing hospital staff and attending provider of covered benefits as indicated.

Chapter 11 — Prior authorization

The requesting provider is responsible for complying with Aetna Better Health's prior authorization requirements, policies, request procedures, and for obtaining an authorization number to facilitate reimbursement of claims. Aetna Better Health will not prohibit or otherwise restrict provider, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and member of Aetna Better Health about the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Access to our Utilization Medical team

For members and providers who may need access to one of our nurses:

- During business hours (8 a.m. to 5 p.m.), they can call inbound collect, or **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus) and ask to be connected to a nurse. This number also applies to case or disease management nurses. If case or disease management nurses are not available, callers have the option of leaving a message, and they will be called back by the end of the next business day. Staff is identified by name, title and organization name when initiating or returning calls regarding UM issues.
- After business hours, members can call **800-609-4163** option **6** or TTD **800-828-1120**, and they will be connected to the 24-Hour Nurse Line.
- Members with special communication needs:
  - Who have access to TDD telephones may call **800-828-1120** or **711**. If they cannot reach us at this number, they may contact us through Virginia Relay, toll-free at TDD **800-828-1120** or Voice **800-828-1140**.
  - Language translation services are also provided free of charge by calling **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus).

Providers may call **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus) to request prior authorization, and these requests must include the following:

- Current, applicable codes (may include):
  - CPT.
  - ICD-10.
  - CMS HCPCS codes.
  - National Drug Code (NDC).
- Name, date of birth, sex, and identification number of the member.

- Name, address, phone, and fax number of the treating providers.
- Problem/diagnosis, including the ICD-10 code.
- Presentation of supporting objective clinical information, such as:
  - Clinical notes.
  - Laboratory and imaging studies.
  - Prior treatments.

All clinical information should be submitted with the original request.

Timeliness of decisions and notifications to providers and/or members

Aetna Better Health makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by DMAS, Aetna Better Health adheres to the following decision/notification time standards.

Decision	Decision timeframe	Notification to	Notification method
Urgent preservice approval	Based on members need but no more than 72 hours/3 calendar days from receipt of request	Provider	Oral or electronic/written
Urgent preservice denial	Based on members need but no more than 72 hours/3 calendar days from receipt of request	Provider and member	Oral and electronic/written
Non-urgent preservice approval	Based on members need but no more than 14 calendar days from receipt of the request	Provider	Oral or electronic/written
Nonurgent preservice denial	Based on members need but no more than 14 calendar days from receipt of the request	Provider and member	Oral and/ electronic/written
Urgent concurrent approval	72 hours/3 calendar days of receipt of request	Provider	Oral or electronic/written
Urgent concurrent denial	72 hours/3 calendar days of receipt of request	Provider	Oral and electronic/written
Post-service approval	30 calendar days of receipt of request	Provider	Oral or electronic/written
Post-service denial	30 calendar days from receipt of the request.	Provider and member	Electronic/written
Termination, suspension reduction of a previously authorized service	At least 10 calendar days before the date of the action.	Provider and member	Electronic/written
Pharmacy Review Medical Drugs	24 hours of receipt of request	Provider	Oral and electronic/written
Oncology Treatment Plans (Eviti Vendor)	24 hours of receipt of request if injectable, Non-injectables 72 hours/3 calendar days	Provider	Oral and electronic/written

High Cost Drug Reviews (GCIT)	24 hours of receipt of request	Provider	Oral and electronic/written

If Aetna Better Health approves a request for expedited determination, a notification will be sent to the member and the provider involved, as appropriate, of its determination as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.

If Aetna Better Health denies a request for an expedited determination, the request will automatically be transferred to the standard time frame. Aetna Better Health will promptly provide the member oral notice of the denial of an expedited review and of their rights. Aetna Better Health will send to the member within 72 hours, a written letter of the members' rights.

Out-of-network providers

When approving or denying a service from an out-of-network provider, Aetna Better Health will assign a prior authorization number, which refers to and documents the decision. Aetna Better Health sends documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request.

Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health makes such decisions on a case-by-case basis in consultation with Aetna Better Health's Medical Director(s).

Prior authorization list

Treating providers must request authorization for certain medically necessary services. (See attachments.)

A complete and current list of services that require prior authorization can be found online at www.aetnabetterhealth.com/Virginia. Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment.

Prior authorization and coordination of benefits

If other insurance is the primary payer before Aetna Better Health, prior authorization of a service is required. If the service is not covered by the primary payer, the provider must follow Aetna Better Health's prior authorization rules.

How to request prior authorizations

A prior authorization request may be submitted by:

- 24/7 secure Provider Portal.
- Faxing the request form to **855-661-1828** (forms are available at **AetnaBetterHealth.com/Virginia/providers/library**).
    - Please use a cover sheet with the practice's correct phone and fax numbers to safeguard PHI and facilitate processing.

Call the Prior Authorization department directly at **800-279-1878** (Medallion and FAMIS) or **855-652-8249** (CCC Plus).

Chapter 12 – Quality Management

Aetna Better Health's quality management (QM) program is designed to continuously improve and monitor the medical care, member safety, behavioral health services, and the delivery of services to members, including ongoing assessment of program standards to determine the quality, accessibility and appropriateness of care, case management and coordination. A key focus of our quality program is improving the member's biological, psychological, and social well-being with an emphasis on quality of care and the non-clinical aspects of all services. Where the member's condition is not amenable to improvement, our goal is to maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. Incorporating the continuous quality improvement (CQI) concept, our quality program is comprehensive and integrated throughout Aetna Better Health and the provider network. We promote the integration of our quality management activities with other systems, processes, and programs throughout Aetna Better Health.

Quality management is a company-wide endeavor, that uses an integrated and collaborative approach involving each functional area to monitor processes and activities (such as those for referring quality of care/risk issues, member/practitioner complaints, grievances and appeals), business application systems, and databases that are accessible to all areas. Our quality program also includes a structure of oversight committees with representation not only from across Virginia, but from the provider network and member population as well.

Program purpose

Aetna Better Health's QM Program allows the health plan the flexibility to target activities that focus on patterns identified at the local market level. The QM Program provides a structure for promoting and achieving excellence in all areas through continuous improvement. It provides the framework for Aetna Better Health to continually monitor, evaluate, improve the quality of care, safety, and services provided to all members, employers, practitioners/providers, and external/internal customers. The program provides an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services. Core values of the program include maintaining respect and diversity for members, providers, and employees.

The QM program is a commitment to innovation, affordability, professional competence and continuous learning, teamwork, and collaboration. The clinical aspects of the QM Program are structured from evidence-based medicine. The QM Program also ensures health services needs of members, including those with limited English proficiency and diverse cultural and ethnic backgrounds are met. The QM Program supports efforts to attain an understanding of the populations served, in terms of age groups, disease categories, and special risk status through analysis, monitoring, and the evaluation of processes. The quality of care and services are optimized and continuously improved while maintaining cost effective utilization of health care resources. This is accomplished by systematic monitoring and evaluation of provided services and by actively pursuing opportunities for improvement. The program addresses activities related to QM, utilization management (UM), customer service, member rights and responsibilities, member experience, practitioner/provider credentialing and re-credentialing, risk management and delegation vendor/entity oversight.

The QM Program promotes member compliance with recommended preventive health services. Standards are set and monitoring is done to ensure these services remain a focus. Preventive health care remains the key to the attainment of improved member health and satisfaction and a cost-effective health plan. Members are educated about age specific preventive care.

The process of Utilization Management plays a vital role in the QM program including, but not limited to, concurrent review and pre-authorization programs, identification of potential quality of care issues and potential under and over-utilization.

The QM Program consists of the following elements:

- Annual QM Program Description Summary
- Policies & Procedures
- Annual QM Program Evaluation
- Annual QM Work Plan
- Quality Improvement Activities
- QM Committee Structure

Employees must avoid situations where their personal interest could conflict or appear to conflict with their responsibilities, obligations, or duties to the Health plan's interest or present an opportunity for personal gain apart from the normal compensation provided through employment. Aetna Better Health does not use incentives to reward restrictions of care. Utilization management decision making is based only on appropriateness of care and service and existence of coverage. Aetna does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. No reviewing provider may perform a review on one of his/her patients, or cases in which the reviewing provider has a proprietary financial interest in the site providing care.

It is Aetna Better Health's policy to conduct business in a manner that protects the privacy of our members. Confidentiality is maintained in accordance with federal and state laws. Confidential information requested, used and disclosed in the course of an investigation, is limited to the minimum amount necessary to accomplish the intended purpose; and controlled to maintain confidentiality and to minimize health plan access to a "need to know" basis. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Contracted participating practitioners and providers are required by contract to:

- Cooperate with QI activities
- Maintain the confidentiality of member information and records
- Allow the plan to use practitioner performance data

All committee minutes and reports are considered confidential. All external committee members are required to sign a confidentiality and conflict of interest statement prior to serving on a committee. All health plan employees sign a confidentiality agreement as a condition of employment and receive annual training HIPAA and confidentiality policies.

Aetna Better Health's quality management program goals include the following:

- Promote collaboration among Aetna Better Health departments and systems to allow for the collection and sharing of quality management data and monitoring of outcomes
- Work in collaboration with providers to actively improve the quality of care provided to members
- Maintain compliance with federal and state regulatory requirements and consistency with the quality plan and all other requirements of the contract as defined by DMAS in the quality strategy
- Evaluate identified quality, risk and utilization issues, and develop follow-up measures (including action plans) to resolve the issues and prevent recurrences
- Define criteria for measuring clinical and non-clinical performance and assessing the outcomes against established standards and benchmarks, including HEDIS® measures

- Assess and identify opportunities for improvement by performing quality management and performance improvement activities as requested by internal and external customers (including regulatory agencies). This assessment process will ideally be based on solid data and focused on high volume/high risk procedures or other services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided.
- Identify, monitor and evaluate high-volume, problem-prone or high-risk aspects of health care and service
- Provide feedback to members and their family/representative and/or caregiver, advocates, practitioners, providers and Aetna Better Health staff
- Maintain mechanisms for reviewing the entire range of care delivery systems, including all demographic groups, care settings, and services available to the member (e.g., annual population assessment)
- Monitor the provider network's capacity to accommodate the diverse needs of the member population, including special health care needs as well as specific language or cultural needs and preferences. The evaluation of access includes analysis of services to members with disabilities.
- Monitor outpatient and inpatient services to identify deviations from standard of care/service
- Identify opportunities to educate members and their family/representative and or caregiver, advocates, practitioners, providers, and Aetna Better Health staff about quality management and performance improvement activities and outcomes and ways to improve members' health
- Develop, maintain, and increase awareness of prevention and wellness and outreach programs available to members (to include programs addressing chronic and catastrophic illness, behavioral health, long term care and care management)
- Incorporate an awareness of member safety into all quality activities
- Maintain technical business information systems to support quality management and performance improvement activities and improve them as necessary to meet program needs
- Inform members and practitioners of members' rights and responsibilities

Our objectives in the administration of our quality management program include the following:

- Take action on identified opportunities for improving health care outcomes for members and monitor for continued effectiveness
- Educate providers and members and their family/representative and/or caregiver on appropriate and efficient utilization of health care services and facilities
- Maintain systems for monitoring and tracking practitioner and provider quality management and performance improvement trends and medical record keeping practices
- Maintain integrated processes to support quality management and performance improvement activities
- Manage quality and risk management referrals in order to promote optimum quality of care and service
- Evaluate practitioner and ancillary provider quality and utilization management and take action to improve areas showing opportunities for improvement
- Credential and re-credential practitioners and other network providers in a thorough and timely manner, and in accordance with state and NCQA standards
- Inform and educate members and their family/representative and/or caregiver, practitioners, providers, and other stakeholders about quality and health improvement programs in order to increase the utilization of preventive health care, care management and other services

- Monitor and evaluate the continuity, availability, and accessibility of care or services provided to members
- Compile practitioner and provider information (such as quality or risk management trends, outcomes, and other information) into practitioner and provider information files
- Provide feedback to members and their family/representative and/or caregiver, practitioners, and providers on the success of quality management and performance improvement activities, including health outcomes
- Improve the satisfaction of members, practitioners, and providers with health care delivery
- Assist members with navigating the health care delivery system
- Establish standards of clinical care and service utilizing objective criteria and processes to evaluate and continually monitor for improvement
- Develop and maintain integrated systems and processes for collecting and disseminating quality data and information
- Integrate oversight of practitioner/provider quality and utilization management and take action if needed to promote improvement
- Promote involvement of members and their family/representative and/or caregiver and practitioners in the quality management program and related activities by encouraging feedback (e.g., through member/provider satisfaction surveys, telephone calls, participation on committees, as applicable)
- Promote performance-based reimbursement models that connect provider reimbursement to performance against a defined set of quality and utilization metrics. Reimbursement models include but are not limited to shared savings/risk programs, care coordination fees, pay for quality, and episode bundled payment arrangements.

Additional information about the QM program goals and outcomes as they relate to member care and services can be found on our website at **AetnaBetterHealth.com/Virginia/providers/provider-quality**. An annual QM summary highlights our accomplishments and can be obtained by contacting Provider Services. We also communicate outcomes in the provider newsletters.

Patient safety

Aetna Better Health has a patient safety program in place which is intended to support practitioners and providers (e.g., hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, behavioral health facilities), in their efforts to monitor for and reduce the incidence of medical errors. The program may include one or more of the following; prescription drug utilization review and tracking and trending of adverse events; prior authorization of pharmacy claims to ensure medical appropriateness and prevent unsafe prescribing; analysis of procedure and/or diagnosis codes to identify opportunities for improvement in medical practices and communicate any findings directly to the practitioner and/or provider involved; and education of providers and members about prevention and detection of unsafe practices.

Governing body

The Aetna Better Health Board of Directors has delegated ultimate accountability for the management of the quality of clinical care and service provided to members to the Chief Medical Officer (CMO). The CMO is responsible for providing national strategic direction and oversight of the QM Program for Aetna Better

Health members. The Board of Directors delegates responsibility of the health plan quality improvement process to the Quality Management Oversight Committee (QMOC), which oversees the quality program.

Program accountability – Board of Directors

Aetna Better Health Board of Directors has ultimate accountability for the QAPI and related processes, activities, and systems. This includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through the health delivery network. The chief executive officer on behalf of the Quality Management Oversight Committee submits the QAPI and any subsequent revisions to the board of directors for approval. In addition, the chief executive officer annually submits to the board of directors an evaluation of the previous year's QAPI activities, summary reports, data, outcomes of studies and credentialing activities (i.e., annual evaluation). The proposed annual QAPI work plan is also submitted to the board of directors for approval. After evaluating the information, the board of directors may provide further direction and recommendations to the Chief Executive Officer for enhancements to the QAPI and work plan.

Committee structure

Quality management and performance improvement activities are reported to the board of directors through the following committees:

- Quality Management Oversight Committee (QMOC)
- Quality Management/Utilization Management Committee (QM/UM)
- Delegation Committee
- Aetna Credentialing and Performance Committee (CPC)
  - Aetna Practitioner Appeal Committee (PAC)
- Aetna Quality Oversight Committee (QOC)
- Drug Utilization Review (DUR) Board
- Service Improvement Committee (SIC)
  - Grievance and Appeals Committee
- Member Advisory Committee
- Compliance Committee (CC)
- Policy Committee (PC)

Quality Management Oversight Committee (QMOC)

The Quality Management Oversight Committee's primary purpose is to integrate quality management and performance improvement activities throughout the health plan and the provider network. The committee is designated to provide executive oversight of the QAPI and make recommendations to the board of directors about Aetna Better Health's quality management and performance improvement activities, including the annual QAPI, work plan and evaluation and work to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations, and network providers.

Quality Management/Utilization Management Committee (QM/UM Committee)

The Quality Management/Utilization Management (QM/UM) Committee's primary purpose is to advise and make recommendations to the Chief Medical Officer on matters pertaining to the quality of care and service provided to members including the oversight and maintenance of the QAPI and utilization management program. Summary reports are submitted to the Quality Management Oversight Committee for review/approval and board of directors.

Delegation Committee

Aetna Better Health does not delegate QAPI activities. Aetna Better Health may delegate limited health plan activities. The Delegation Committee advises and makes recommendations to the QMOC about delegated relationships.

Aetna Credentialing and Performance Committee (CPC)

The Aetna Better Health Quality Management Oversight Committee (QMOC) has delegated decision-making authority to the Aetna Credentialing and Performance Committee's (CPC). This committee is responsible for credentialing and recredentialing individual providers (i.e., practitioners) who deliver services to members. This committee is also responsible for conducting professional review activities involving the providers whose professional competence or conduct adversely affects, or could adversely affect the health or welfare of members.

Aetna Practitioner Appeals Committee (PAC) - subcommittee to CPC

The purpose of the Aetna Practitioner Appeals Committee (PAC) is to conduct professional review hearings of providers who appeal decisions made by the Aetna Credentialing and Performance Committee involving professional competence or conduct of the provider. The committee, which is, facilitated by an Aetna medical director, consists of providers who are appointed on an ad hoc basis by the Aetna Credentialing and Performance Committee. The committee reports through CPC and to the Aetna Better Health QMOC.

Aetna Quality Oversight Committee (NQOC)

The Aetna Better Health Quality Management Oversight Committee (QMOC) has delegated authority to the Aetna Quality Oversight Committee (QOC) to conduct the credentialing/recredentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors potential quality of care issues and complaints.

Service Improvement Committee (SIC)

The Service Improvement Committee advises and makes recommendations to the Quality Management Oversight Committee and/or Aetna Better Health management about customer (member and provider) issues.

Grievance & Appeals Committee

The Grievance & Appeals Committee reviews expression of dissatisfaction by members, including complaints. The committee also reviews issues decisions on appeals that are filed by members or providers on behalf of members.

Member Advisory Committee (MAC)

The Member Advisory Committee (MAC) solicits enrolled member feedback and opinion regarding issues related to access and the quality of care and services provided to members as well as potential programs, activities and educational materials. Members provide feedback to Aetna Better Health aimed at improving member care and services.

Drug Utilization Review (DUR) Board

The DUR is designed to analyze member and practitioner/provider drug utilization patterns to identify educational and/or intervention opportunities that promote patient safety and appropriate utilization, monitor quality outcomes, and to drive cost-effective drug therapy.

Compliance Committee (CC)

The Compliance Committee (CC) reviews, monitors, and assesses the effectiveness of Aetna Better Health compliance plan.

Policy Committee (PC)

The Policy Committee purpose is to provide a forum for the consistent development, implementation, approval, and communication of all Aetna Better Health policies.

Member profiles

Member profiles play a pivotal role in the management of member care both by Aetna Better Health's integrated care management team, as well as by the member's medical home/PCP. Member profiles are used to:

- Identify members who have under-or-over utilized health services, including emergency department services, hospital admissions and prescribed medications, and could benefit from integrated care management services
- Identify members who may lack appropriate access to needed services or could benefit from education about how to best utilize the health care system (e.g., persons with high emergency room utilization, or lack of preventive service utilization)
- Identify medical homes/PCPs that do not appear to be following recommended clinical practice guidelines or need to more effectively reach out to their assigned members and facilitate better management of the member's care
- Assist in supporting other internal health plan operations, such as concurrent review decisions, member appeals, and fraud and abuse detection

Provider profiles

Aetna Better Health uses the provider profile to monitor a provider's utilization practices along with members' health outcomes to identify opportunities for improvement. The objectives of the provider profiles are to identify provider utilization patterns that vary significantly from peer network provider groups; identify trends that can be addressed through provider outreach; provide information to network providers about their practice patterns; safeguard confidentiality by maintaining secure access to the profile interface; provide information to be used as a component of quality management oversight; and provide information to be used as a component of provider incentive compensation.

Member and provider satisfaction surveys

Member and provider satisfaction with health care services is assessed to discover areas that are working well and identify opportunities for improvement. Member surveys are conducted by an Aetna Better Health approved vendor using nationally standardized survey items. The results are distributed to members, providers, and DMAS. Additional focused surveys of specific populations or users of identified

services may be conducted at the discretion of the Chief Executive Officer. Member surveys include but are not limited to questions related to availability and accessibility of healthcare, practitioners, utilization, quality of care and service, quality of member services, requests to change practitioners and/or sites, and cultural competency. Provider surveys address satisfaction with Aetna Better Health's utilization management procedures (prior authorization, concurrent review), claims processing, and Aetna Better Health's response to inquiries.

When areas for potential improvement are identified from member or provider surveys or other sources (such as member complaints, grievances/appeals or PIPs), Aetna Better Health uses a formal process to evaluate the areas identified. The identified issues are prioritized and concerns addressed; interventions are implemented, and the issue is reassessed to determine change and satisfaction.

Clinical Practice Guidelines

Aetna Better Health uses evidence-based clinical practice guidelines. The guidelines consider the needs of members, opportunities for improvement identified through our QM Program, and feedback from participating providers. Guidelines are updated as appropriate, but at least every two years. Aetna Better Health adopts and distributes clinical practice guidelines. The link is available on our website at **AetnaBetterHealth.com/Virginia/providers/guidelines**. Aetna Better Health also adopts behavioral health guidelines from the American Psychiatric Association. We provide information about updated guidelines in the Provider Newsletters.

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public has the information it needs to compare performance of managed health care plans reliably. Aetna Better Health collects this data annually.

Why do health plans collect HEDIS data?

The collection and reporting of HEDIS data are required by the Center for Medicare and Medicaid Services (CMS) and DMAS. Accrediting bodies such as the National Committee for Quality Assurance (NCQA), along with many states, require that health plans report HEDIS data, The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes, and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

How are HEDIS measures generated?

HEDIS measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)
- Survey

Why does the plan need to review medical records when it has claims data for each encounter?

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings, and results of test that may not be available in claims/encounter data. Typically, a health plan employee will call the provider's office to

schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the provider to fax or mail the specific information.

How accurate is the HEDIS data reported by the plans?

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the health plan will ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the plan?

The HIPAA Privacy Rule permits a provider to disclose protected health information to the health plan for the quality related health care operations of the health plan, including HEDIS, provided the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 § CFR 164.506 (c) (4). Thus, a provider may disclose protected health information to a health plan for the plan's HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

May the provider bill the plan for providing copies of records for HEDIS?

Providers may not bill either the plan or the member for copies of medical records related to HEDIS. Aetna Better Health of Virginia does not contract with third party healthcare information management companies and does not reimburse medical record vendors, nor the fees associated with practitioners delegating medical record copying services to an outside vendor.

How can providers reduce the burden of the HEDIS data collection process?

We recognize that it is in the best interest of both the provider and the plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include providing the plan remote access to provider electronic medical records (EMRs) and setting up electronic data exchange from the provider EMR to the plan. Please contact the QM department for more information.

How can providers obtain the results of medical record reviews?

The plan's QM department can share the results of the medical record reviews performed at provider offices and show how results compare to that of the plan overall. Please contact the QM department for more information.

Chapter 13 —Billing and claims

Aetna Better Health processes claims for services provided to eligible members in accordance with applicable policies and procedures. Aetna Better Health will comply with all applicable state and federal laws, rules, and regulations related to claim adjudication.

Aetna Better Health's claim processing system is QNXT. Both electronic and paper claims submissions are accepted. To assist Aetna Better Health in processing and paying claims efficiently, accurately, and timely, the health plan highly encourages providers to submit claims electronically, when possible. To facilitate electronic claims submissions, Aetna Better Health has developed a business relationship with Change Healthcare (formerly Emdeon). Aetna Better Health receives EDI claims directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance, member enrollment, and then uploads them into QNXT each business day. Within 24 hours of file receipt, Aetna

Better Health provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

If you are not currently enrolled with Change Healthcare and would like to be able to submit claims electronically, please click this link to enroll.

When to bill a member

All providers are prohibited from billing any member beyond the member's cost sharing liability, if applicable, as defined on the Aetna Better Health remittance advice.

When to file a claim/timely filing of a claim

All claims, even those services where a per member, per month is paid, must be submitted to Aetna Better Health. All claims should be submitted timely. Our timely filing guidelines are as follows:

- New claim submissions — Claims must be filed on a valid claim form within 365 days from the date services (unless there is a contractual exception). For hospital inpatient claims, date of service means the date of discharge of the member.
- In the event that another payer is prime, providers have 365 days from the date of the remittance advice to submit a coordination of benefits claim.
- Adjustments of claims must be identified and submitted within 365 days from the date of the adjudication decision (either an incorrect payment or an incorrect denial).
- Please refer to Chapter 14 for reconsideration/appeal guidelines.

Failure to submit accurate and complete claims within the prescribed time period may result in payment delay and/or denial.

How to file a claim

1) Select the appropriate claim form.
   a. Medical and professional services should use current version of the *CMS 1500 Health Insurance Claim Form*, if submitting paper. If submitting electronically, use the ANSI 837P.
   b. Hospital inpatient, outpatient, skilled nursing, and emergency room services should use *UB-04*, if submitting paper. If submitting electronically, us the ANSI 837I.
   c. Rural health clinics and federally qualified health centers should use *UB-04* or *CMS 1500*, as appropriate for the services rendered, if submitting paper claims. For electronic claims, use the 837I or 837P, as appropriate.
   d. Please contact Provider Relations with additional questions.
2) Complete the claim form.
   a. Paper claims must be legible and suitable for imaging for record retention. This includes attachments. Complete all required fields and include additional documentation when necessary.
   b. For both electronic and paper, if the claim fails data entry requirements, is illegible, has poor-quality copies and/or required documentation is missing, the claim will be voided (unaccepted).. If these are not corrected timely, this could result in the claim being denied for untimely filing.
3) Submit your claims electronically or mail the original claim to the address provided below. Faxed claims are not routinely accepted.
   a. To submit a paper claim and/or include supporting documentation, such as members' medical records, clearly label and send to:

Aetna Better Health
P.O. Box 63518
Phoenix, AZ 85082-3518

EDI Information

1) Payer ID: 128VA
4) Electronic Clearing House - Providers who are contracted with us can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Change Healthcare (formerly Emdeon) is the EDI vendor we use.
5) Please complete the ERA form on our website under the Document Library tab to sign up to receive your remittance advise electronically, ANSI 835
6) Electronic fund transfers (EFT) can be established with Aetna Better Health by completing and submitting the EFT form located on Aetna Better Health's website. More information can be found in our Document Library here.
7) Claim filing tips
   - Corrected claims must be clearly identified as a resubmission by stamping/writing "corrected claim" or "resubmission" on the paper claim form. If submitting electronically, the frequency code in the CLM05-3 segment in the 2300 Claim Loop must show a "7" for a replacement/adjustment claim or an "8" if the claim is to be voided.
   - Altered claims must be clearly initialed at the correction site. Initialing corrections ensures the integrity of a corrected claim.
   - Aetna Better Health uses a claim system that process a claim as a document. Therefore, when corrected claims are submitted, the corrected claim must include all of the original claim lines. Resubmitted claims without all of the original claim lines may result in the adjustment and possible recoupment of the wrong claim line.
   - Dates of service on the claim should fall within the prior authorized service date range. Including dates of services outside the authorized range may result in denials.
   - Claim for services that require an authorization, QNXT will search the members available authorizations. It does this based on matching criteria:

Pass	Member ID	Date of Service	Rendering Provider	Pay to Provider	Service Code	Then. . .
1	✓	✓	✓	✓	✓	Auth is selected
2	✓	✓			✓	Edit will fire to manually verify provider. If match is found, auth is selected; otherwise, claim will deny for no authorization.
3	✓	✓	✓	✓		Edit will fire to manually verify service code. If match is found, auth is selected; otherwise, claim will deny for no authorization.
4	✓	✓				Edit will fire to manually verify provider and service code. If

						match is found, auth is selected; otherwise, claim will deny for no authorization.
5						No match is found, deny service for no authorization.

- Claims must have current, valid, and appropriate ICD diagnosis codes.
- The diagnosis codes must be coded to the highest degree of specificity (fifth digit) to be considered valid.
- Claims must be submitted with valid CPT, HCPCS, and/or revenue codes.
- Claims submitted with nonstandard CPT, HCPCS, revenue codes, or modifiers will NOT be processed and will be returned to the provider. These claims should be reworked and submitted timely to the initial claims address.
- Each CPT or HCPCS code line must have a valid place of service (block 24B) code when billing on a *CMS-1500* form.
- Accident details should be provided when applicable (Block 10B of CMS-1500 Form).
- List all other health insurance coverage when applicable (Block 9A-D of CMS-1500 Form).
- Providers must submit the appropriate NPI numbers in Block 33A of the CMS-1500 and Block 56 of the *UB-04*.
- Billing provider taxonomy information should be submitted (Block 33B of the *CMS-1500* form)
- All providers, including federally qualified health centers and rural health clinics, must submit their claims listing out their usual and customary charges as the billed amounts on the applicable claim form.

NDC requirements

The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer.

Federal regulations require states and managed care organizations to collect NDC numbers from providers on claims for the purposes of billing manufacturers for drug rebates. As a result, providers will not be reimbursed for drugs unless a valid 11-digit NDC number, unit of measure, and quantity administered are reported on the UB04 or CMS 1500 claims.

A complete NDC data set consists of the following:

- An 11-digit National Drug Code number
- Unit of measure code
    - F2: International unit
    - GR: Gram
    - ML: Milliliter
    - UN: Unit
- NDC units are based on the numeric quantity administered to the patient and the unit of measurement. The actual metric decimal quantity administered, and the unit of measurement is required for billing.

- Provider must submit Revenue Codes, HCPCS Codes and related service units in addition to the required NDC information. This is required because claims are priced based on revenue, HCPCS or CPT codes and the units of service. If the NDC number on the claim doesn't have a specific revenue, HCPCS or CPT code assigned to it, please assign the appropriate miscellaneous code.
- If the NDC data set is missing, incomplete, or invalid, Aetna Better Health will deny the affected claim line. The claim will need to be resubmitted with the required NDC information and/or correct number of units within the time allowed for potential payment.
- If the medication comes in a box with multiple vials, using the NDC on the box (outer packaging) is recommended.

It should be noted that many NDC numbers are displayed on drug packing in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting an NDC from a 10-digit to an 11-digit format requires a strategically placed zero, dependent upon the 10-digit format. The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format, using the proper placement of a zero. The correctly formatted, additional "0" is in a bold font and underlined in the following example. Note that hyphens indicated below are used solely to illustrate the various formatting examples for an NDC. Spaces or hyphens should not be used when entering the actual data in your claim.

Converting NDCs from 10-digits to 11-digits					
10-Digit Format on Package	10-Digit Format on Example	11-Digit Format	11-Digit Format Example	Actual 10-digit NDC Example	11-Digit Conversion of Example
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99	0002-7597-01	**0**0002-7597-01
5-3-2	99999-999-99	5-4-2	99999-**0**999-99	50242-040-62	50242-**0**040-62
5-4-1	99999-9999-9	5-4-2	99999-9999-**0**9	60575-4112-1	60575-4112-**0**1

Billing Instructions

All institutional and professional claims must include the following information:

- NDC and unit of measurement for the drug billed
- HCPCS/CPT code and units of service for the drug billed
- The actual metric decimal quantity administered

NOTE: Virginia Medicaid requires the use of the Unit of Measurement Qualifiers following the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity.

Examples of NDC quantities for various dosage forms as follows:

- Tablets/Capsules – bill per UN
- Oral Liquids – bill per ML
- Reconstituted (or liquids) injections – bill per ML
- Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
- Creams, ointments, topical powders – bill per GR
- Inhalers – bill per GR

UB04 Claim Form

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above).
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.
- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

CMS 1500 Claim Form

To report the NDC on the CMS 1500 claim form, enter the following information:

- In Field 24A of the CMS 1500 form in the shaded area, enter the NDC Qualifier of 4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

837I/837P Claims Submission for NDC:

ANSI Page	Loop	Segment	Data Element	Comments
352	2400-Service Line	SV1	SV101-1-Product or Service ID Qualifier	Use "HC" for HCPCS Codes NDCs will not be processed in this segment; however, an NDC must be sent in the LIN segment to supplement a drug HCPCS code. For Agency Directed (AD) services, this is the type of service (procedure) code performed for EVV requirements.
427	2410-Drug Identification	LIN	LIN02-Product or Service ID Qualifier	Use "N4" for NDC
427	2410-Drug Identification	LIN	LIN03-National Drug Code	An NDC is required when a drug is dispensed. Aetna Better Health will capture only the first occurrence of the LIN segment for each service line. If billing for a compound medication with more than one NDC, then

				each applicable NDC must be sent as a separate service line.
429	2410-Drug Identification	CTP	CTP04-Quantity	Input the actual NDC quantity dispensed
430	2410-Drug Identification	CTP	CTP05-Composite Unit of Measure	Input the unit/basis of measure

Special Billing Instructions

Tuberculosis Oral Drugs

- Health Department clinics should bill for all drugs using the unlisted HCPCS code J8499. Modifier U2 must be used in Block 24-D of the CMS-1500 (02-12) claim form. Clinics bill Medicaid with their actual cost for the drugs. If no modifier is billed, the claim may be denied. The qualifier 'N4' should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family Planning Drugs and Devices

- Birth control pills must be billed using code J8499 along with modifiers FP and U2 in
- Block 24-D of the CMS-1500 (02-12) claim form. The qualifier 'N4' should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

You can find more information about NDC online:

- The U.S. Food and Drug Administration (FDA) package insert includes the NDC information. Online, the FDA publishes an online searchable National Drug Code Directory and has other public resources
- The Centers for Medicare & Medicaid Services (CMS) publishes a CMS HCPCS/NDC Crosswalk
- RJ Health Systems' reimbursementcodes.com, an NDC coding product (a fee may be associated with using this product, contact the vendor directly if you have questions.)

Multiple procedures

Multiple procedures performed on the same day and/or at the same session are processed at 100% of the contracted rate for the primary procedure, 50% of the contracted amount for the secondary procedure, and 50% of the contracted amount for any subsequent procedures; or as defined by a provider's current contract with Aetna Better Health or Medicaid guideline changes.

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health can request copies of operative reports or office notes to verify services provided. Certain modifiers may affect payment amounts as defined by the State of Virginia Medicaid Fee Schedule or contract with Aetna Better Health. Common modifier issue clarification is below:

- **Modifier 59 — Distinct Procedural Services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261-77499).
- **Modifier 25 — Significant, Separately Identifiable Evaluation and Management Service by the Same Provider on the Same Day of the Procedure or Other Service** - must be attached to a

component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.

- **Modifier 50 — Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, a provider may bill the component code with modifier 50. Services should each be billed on one line reporting one unit with a 50 modifier.
- **Modifier 57 — Decision for Surgery** — must be attached to an Evaluation and Management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period.

Please refer to the CPT Manual for further detail on proper modifier usage.

Correct coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure.
- Are necessary to accomplish the comprehensive procedure.
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect coding

Examples of incorrect coding include:

- "Unbundling," or fragmenting one service into components and coding each as if it were a separate service or billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service in order to use an additional code when a higher level, more comprehensive code is appropriate.

Correct coding initiative

Aetna Better Health utilizes claims editing systems designed to evaluate the appropriate billing information and CPT coding accuracy on procedures submitted for reimbursement. Our edit guidelines are based on, but not limited to NCCI, CPT-4, HCPCS, and ICD coding definitions, AMA and CMS guidelines, specialty edits, pharmaceutical recommendations, industry standards medical policy, and literature research input from academic affiliations.

The major areas of reviews are:

- Procedure Unbundling - Billing two or more individual CPT codes to report a procedure when a single more comprehensive code exists that accurately describes the procedure.
- Incidental Procedures - A procedure that is performed at the same time as a more complex procedure; however, the procedure requires little additional provider resources and/or is clinically integral to the performance of the primary procedure.
- Mutually Exclusive Procedures - Two or more procedures that are billed, by medical practice standards, should not be performed or billed for the same patient on the same date of service.
- Multiple Surgical Procedures - Surgical procedures are ranked according to clinical intensity and paid following percentage guidelines.

- Duplicate Procedures - Procedures that are billed more than once on a date of service.
- Assistant Surgeon Utilization - Determination of reimbursement and coverage.
- Evaluation and Management Service Billing - Review the billing for services in conjunction with procedures performed.

When reviewing a remittance advice, any CPT code that has been changed or denied by the editing system will be noted by the appropriate disposition code.

Submission of itemized billing statements

Aetna Better Health may require that providers submit an itemized billing statement along with their original claims. Claims billed in excess of $50,000.00 will require an itemized billing statement. If an itemized billing statement is not received, then the claim will be denied for an itemized billing statement.

Interim Claims Billing

Aetna Better Health does follow DMAS guidelines for Interim Claims

- Interim claims should be billed with a patient status of 30 with at least 60 days billed
- Virginia has the yearly timely filing (365 days) so the entire stay can be billed within that time. This can be found on our website, provider manual and the Quick Reference Guide.
- However, for Aetna Better Health, we will pay every interim claim submitted but the final claim (itemized bill) will be reviewed, and previous associated interim claims will be retracted, and the final bill will be paid. These claims must be billed with patient status 30 and at least 60 days. Also, remember Virginia has 365 days of timely filing. Keep in mind, these are usually high dollar claims and will be reviewed by the high dollar team.
- The final bill must include the entire stay (all dates of services) for that inpatient stay. (bill type 114)

Balance billing

Aetna Better Health participating Providers are prohibited, by contract, from billing members for any balance of payment other than copays for covered services, or as otherwise permitted under applicable law. Providers accept reimbursement from Aetna Better Health in full.

A provider may seek reimbursement from a member when a service is not a covered benefit and the member has given informed written consent before treatment that they agree to be held responsible for all charges associated with the service.

If a member reports that a provider is balance billing for a covered service, the provider will be contacted by an Aetna Better Health Provider Relations Representative to research the complaint. Aetna Better Health is obligated to notify DMAS when a provider continues the inappropriate practice of balance billing a member.

Coordination of benefits

By law, Medicaid is the payor of last resort. Aetna Better Health, as an agency of the Commonwealth of Virginia is considered the payor of last resort when other coverage for a member is identified. Aetna Better Health shall be used as a source of payment for covered services only after all other sources of payment have been exhausted.

These claims must be received by Aetna Better Health within 365 days from the member's primary carrier remittance advice date. A copy of the primary carrier RA and disposition detail must accompany the claim.

Aetna Better Health pursues Third Party Liability claims based on requirements and/or limitations under Aetna Better Health's contract with the State of Virginia.

Participating and/or non-participating Providers are required to follow Aetna Better Health's policies on authorization requirements when Aetna is the primary payer. If the claim is processed as secondary by Aetna Better Health then that payer's authorization rules are applied.

Other general claims instructions

Aetna Better Health claims are paid in accordance with the terms outlined in the provider contract for this product.

Skilled Nursing Facilities

Providers submitting claims for skilled nursing facilities should use *CMS UB-04* form. Providers should bill Aetna Better Health using level of care HCPCS coding (e.g. level of care 101 is billed under HCPCS code LC101). Please bill with the corresponding HCPCS code for services rendered. Please contact the CICR department with additional questions or concerns.

Hospice

Aetna Better Health members currently receiving hospice services are routinely transitioned back to State of Virginia Fee-For-Service Medicaid coverage depending upon contracted line of business Please contact a Care Coordinator or Provider Relations to discuss these services in greater detail.

Service	CCC Plus	FAMIS	Medallion 4.0
Hospice	Yes	Yes	No
Inpatient acute care	Yes	Yes	Yes

Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that providers keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call Provider Relations for more information about electronic remittance advices.

An electronic version of the Remittance Advice can be attained. In order to qualify for an Electronic Remittance Advice (ERA), a provider must currently submit claims through EDI and receive payment for claim by EFT. Providers must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for providers to receive payment and reconcile outstanding accounts. Please contact our Network Relations department for assistance with this process.

There are four levels of hospice care:

1) Routine home care where most hospice care is provided
2) Continuous home care which is furnished during a period of crisis and primarily consists of nursing care
3) Inpatient respite care which is short-term care and intended to relieve family members or others caring for the individual
4) General inpatient care which is short term and intended for pain control or acute or chronic symptom management which cannot be provided in other settings.

Please contact the member's Care Coordinator to discuss these services in greater detail.

The only claims payable during a hospice election period by Aetna Better Health would be additional benefits covered under Aetna Better Health that would not normally be covered under the covered services. All other claims need to be resubmitted to original Medicare for processing, regardless of whether they are related to hospice services or not.

Aetna Better health is not responsible to cover services when a member is in a hospice election period. Aetna Better health will continue to cover only value-added services outside of standard coverage. All claims need to be resubmitted to original Medicare for processing, regardless of whether they are related to Hospice services or not.

This FAQ describes our business practices related to hospice notification/billing room and board, etc.:

Question	Aetna Better Health
How do I submit a hospice notification?	The provider would be required to submit an order along with supporting documentation.
What is the notification process for a higher hospice level of care?	The provider would be required to submit an order along with supporting documentation.
What is the notification timeline?	Requests are received and entered same day. Notification of determination will be verbally communicated to the requesting provider within one business day.
What is the notification process after hours or on weekends?	Call us at **855-652-8249** and press the prompt for preauthorization. The member will be connected with an afterhours nurse to process requests.
What is the appeal process?	**Preservice:** The member or the member's representative can call or write us to file an appeal within 60 days of receiving a *Notice of Adverse Benefit Denial*. Call us: **855-652-8249** Write to us: Aetna Better Health of Virginia PO Box 81040 5801 Postal Road Cleveland, OH 44181 Fax: **1-866-669-2459** **Post-service:** To dispute a claim denial, the provider should follow the instructions and ensure filing within 60 days of the date listed on the remittance advice. The filing should be mailed to the address printed on the remittance advice.
What are the authorization contacts?	Call us at **855-652-8249** (CCC Plus) or **800-279-1878** (Medallion/FAMIS) and press the prompt for preauthorization. The member will be connected with a representative.

Will health plans provide 95% of room and board payment to nursing facilities when a patient elects hospice?	Hospice services provided in a nursing facility will be paid 95% of the RUG-IV Grouper 48 adjusted rate for claims with dates of service on or after **July 1, 2017**.
EFT	Providers are offered EFT when they are contracted with us. Providers who are not currently receiving electronic payments and wish to do so can contact Provider Relations.
Hospice billing codes	Revenue Codes: 0651 - Routine Home Care, 0652 - Continuous Home Care, 0655 - Inpatient Respite Care, 0656 - General Inpatient Care, 0658 - Nursing Facility (billed in conjunction with either revenue code 0651 or 0652; claims must also contain one revenue code 0022), 0551 - Skilled Nursing Visit (billed in conjunction w/procedure code G0299), 0561 - Medical Social Service Visit (billed in conjunction w/procedure code G0155). For nursing facility residents, HIPPS code (RUG code in the 1st 3-digits and assessment code or modifier in the last 2-digits).
Hospice billing instructions and covered services and limitations – reimbursement services as per the wage rule and reimbursement of revenue code 0658	0658 - Nursing Facility: A resident who elected the hospice benefit (one unit = 1 day). Revenue code 0658 must be billed in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 0831. Claims must also contain one revenue code 0022 for each distinct billing period of the nursing facility stay. Hospice providers are reimbursed 95% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care. We also have the discretion to negotiate an alternative payment method with Hospice providers for nursing home room and board services.
Are provider visits covered? How is provider billing handled?	Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected are waived except for services provided by the individual's attending provider, if that provider is not an employee of the designated hospice or receiving compensation from the hospice for those services. (There is an exception for children under 21 who are allowed to receive concurrent medical care, meaning they may continue to receive curative treatment while being enrolled in hospice – see Concurrent Care for Children requirement (§2302 of the Patient Protection and Affordable Care Act). Regarding how billing is handled, the requirements for submission of provider billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed.
Can hospice bill Medicare and Medicaid?	Yes, hospice can bill Medicare and Medicaid for individuals who are eligible.

Where do I submit my claims?	We prefer that provider submit claims electronically. Our EDI Payor ID (Claim) # is 128VA. If electronic submission is not possible, providers may submit paper claims to: Aetna Better Health of Virginia PO Box 63518 Phoenix, AZ 85082-3518
What are the documentation requirements?	See Hospice Manual, Chapter IV starting on page 2 through page 10. Documentation requirements are noted within this chapter.
What constitutes a clean claim?	A "clean" claim is defined as a one that does not require the payer to investigate or develop on a prepayment basis. Clean claims must be filed in the timely filing period.
What will your payment turnaround times be?	Payment turnaround time is 14 days from receipt of a clean claim. Aetna Better Health generates two check runs a week, on Wednesday and Friday.
What are the staffing requirements?	The hospice provider shall design and implement a staffing plan that reflects the types of services offered and shall provide qualified staff in sufficient numbers to meet the assessed needs of all patients, including those patients residing in the provider's hospice facility, if applicable. (12VAC5-391-210(B))
How will Care Coordination interface with hospice?	The patient's plan of care is developed, reviewed, and updated using a coordinated interdisciplinary team approach with the participation of each core service, as well as any other disciplines providing services.
How do I check Medicaid eligibility/certification periods?	For eligibility verification, call Aetna Better Health Member Services at **855-652-8249** or visit the Provider Portal.

Home Health Care

Providers submitting claims for Home Health should use *a UB-04* form. Providers must bill in accordance with their contract and/or State of Virginia Medicaid guidelines.

- Home Health providers billing for Personal Care and Respite services should bill on a *CMS 1500* with the appropriate CPT revenue codes.

DME

Providers submitting claims for DME Rental should use *CMS 1500* form. DME rental claims are only paid up to the purchase price of the DME.

- Providers submitting claims for Durable Medical Equipment (DME) Rental should use CMS 1500 Form.
- DME rental claims are only paid up to the purchase price of the durable medical equipment. Under Medicaid Regulations a DME rental is considered a purchase after 10 months.

Checking status of claims

Providers may check the status of a claim by login into our secure provider portal or by calling the Claims Inquiry Claims Research (CICR) department:

- CCC Plus: **855-652-8249**, listen for desired menu option.

- Medallion & FAMIS: **800-279-1878**, listen for desired menu option.

Online status through Aetna Better Health of Virginia's Secure Provider Portal

- Aetna Better Health of Virginia encourages providers to take advantage of using our online Provider Secure Web Portal. It is quick, convenient, and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The Provider Secure Web Portal is located on the website. The provider must register to use our portal

Calling the Claims Inquiry Claims Research (CICR) Department

The CICR Department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing.
    - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly)
    - Excludes rebilling a claim (the entire claim must be resubmitted with corrections) Please be prepared to give the service representative the following information:
        - Provider name or National Provider Identification (NPI) number with applicable suffix if appropriate
        - Member name, member identification number and date of birth
        - Date of service
        - Claim number from the remittance advice on which you have received payment or denial of the claim

Corrected claims and resubmissions

Providers have 365 days from the date of service to resubmit a corrected version of a processed claim. The review and reprocessing of a corrected claim does not necessarily constitute reconsideration or claim dispute. Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

Ways to submit:
Form
Please submit the Reconsideration/Resubmission Form, along with:

- An updated copy of the claim. All lines must be rebilled; even lines which paid appropriate on initial submission.
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction. Please remember corrections must be made on the claim form.
- Clearly label as "resubmission" or "corrected claim" at the top of the claim in black ink and mail to appropriate claims address.

Failure to mail and accurately label the resubmission to the correct address may cause the claim to deny as a duplicate.

Provider Portal

Please log into the Provider Portal and follow the resubmission process located in the help feature. Note: Upload any and all supporting documentation as needed.

Claim reconsiderations

Providers have 365 days from the date of service to correct and resubmit claims.

- Resubmission: A claim originally denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information
- Reconsideration: A request for the review of a claim that a provider believes was paid incorrectly or denied because of processing errors

A resubmission or reconsideration should be submitted with the *Provider Claims Resubmission/Reconsideration Form* to the following address:

Aetna Better Health of Virginia
Attn: Reconsiderations
PO Box 63518
Phoenix, AZ 85082-3518

Note: Resubmissions may also be submitted through the Provider Portal.

Examples of reconsideration requests:

- Contract interpretation issues
- Timely filing (please submit acceptance report if billed electronic)
- Entire claim denied for no authorization due to the member providing the incorrect insurance information
- Rejected as cosmetic and submitting medical records/documentation
- No authorization when it is required
- Coding edit reconsideration

Timely filing denials

It is the responsibility of the provider to maintain their account receivables records, and Aetna Better Health recommends that providers perform reviews and follow-up of their account receivables on at least a monthly basis to determine outstanding Aetna Better Health claims. Aetna Better Health will not be responsible for claims that were received outside timely filing limits.
Recognizing that providers may encounter timely filing claims denials from time to time, we maintain a process to coordinate review of all disputed timely filing claim denials brought to our attention by providers. If a claim is denied for timely filing, complete the *Provider Claim Resubmission/ Reconsideration Form* available on the Aetna Better Health's website and attach proof of timely filing.

Electronic submission

Electronic claim submission (EDI) reports are available from each provider's claims clearinghouse after each EDI submission. These reports detail the claims that were sent to and received by Aetna Better Health. Providers must submit a copy of the acceptance report from the provider's respective

clearinghouse that indicates the claim was accepted by Aetna Better Health within timely filing limits to override timely filing denial and pay the claim.
Please confirm that the claim did not appear on a rejection report. If Aetna determines the original claim submission was rejected, the claim denial will be upheld and communicated in writing to the provider.

Paper submission

Providers must submit a screen print from the provider's respective billing system or database with documentation that shows the claim was generated and submitted to Aetna Better Health within the timely filing limits.
Documentation should include:

1. The system printout that indicates:
   a. That the claim was submitted to Aetna Better Health.
   b. The name and ID number of the member.
   c. The date of service.
   d. The date the claim was filed to Aetna Better Health.
2. A copy of the original *CMS-1500* or *UB-04* claim form that shows the original date of submission.

Remittance advices

Aetna Better Health generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and to make corrections for any claims requiring resubmission. Call our Provider Relations Department if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the processed amount and the discount/penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the processed amount above. Claims that have refunds applied are noted with a Claim status of REVERSED in the claim detail header with a non-zero refund amount listed.

- The Amount Paid is the total of the net amount, plus the refund amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health after this payment cycle. This will result in a negative amount paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes the:
  - Member name.
  - Member ID number.
  - Date of birth.
  - Account number.
  - Authorization ID, if obtained.
  - Provider name.
  - Claim status.
  - Claim number.
  - Refund amount, if applicable.
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

Please refer to **Attachments** to view a sample remittance advice and check.

Overpayment

Network providers may voluntarily disclose overpayments or improper payments of funds directly to Aetna Better Health. We ask that the provider return the overpayment within sixty calendar days after the date on which the overpayment was identified. Please send the refund check along with an explanation to Aetna Better Health, at the address below.

Aetna Better Health of Virginia
Attn: Finance Provider Refund Check Dept.
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Chapter 14 — Inquiry, grievance and appeals

Aetna Better Health has an inquiry, grievance, and appeals process for members and providers to dispute a claim authorization or an Aetna Better Health decision. This includes both administrative and clinical decisions of Aetna Better Health, including grievances and appeals regarding reasonable accommodations and access to services under the Americans with Disabilities Act. A provider has sixty days (which must be done in writing) and a member has sixty days from the *Notice of Action* to file an Appeal. A provider has sixty days to file a grievance and a member can file a grievance at any time. A

grievance may be filed in writing or by calling Provider Services. Members have a one-level internal appeal process through Aetna Better Health.

There are no punitive actions to members or providers for filing a complaint. Members and providers have the right to submit written comments with all levels of the process.

Provider inquiries and grievances

In order to ensure a high level of satisfaction, Aetna Better Health shall provide a mechanism for providers to express dissatisfaction with Plan decisions. Providers may express questions or dissatisfactions through our provider inquiry and grievances process.

If a provider has questions regarding member benefits/eligibility, claim status/payment, remittance advices, authorization inquires, etc., please access the Provider Portal, or contact the CICR department. Inquiries are handled on a daily basis and are normally resolved on the initial contact.

To submit a dissatisfaction regarding an issue in the Health Plan, you may contact Provider Relations at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus). Complaints received will be documented and forwarded to appropriate personnel for resolution. The resolution will be documented within our internal system and conveyed to the complainant.

After following these steps, if you are still dissatisfied you may have the right to file an appeal. Please refer to the Appeals section for instructions on filing an appeal.

Members and providers also have the right to request and receive a written copy of Aetna Better Health Utilization Management criteria, along with the entire appeal file used when making our determination, in cases where the appeals are related to a clinical decision/denial. Aetna Better Health members will receive assistance, if required, to file either a grievance or an appeal. Aetna Better Health also provides a toll-free number for members at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus). Interpretive services are also available to members by calling the telephone numbers above.

The member may request continuation of benefits during the health plan appeal review or a state fair hearing. The request must be filed within ten days of the mail date of the *Notice of Action*. If Aetna Better Health's action is upheld in a hearing, the member may be liable for the cost of any disputed services furnished while the Appeal was pending determination.

Claim reconsideration vs. claim appeal

Aetna Better Health has two separate and distinct processes designed to assist providers with issue resolution. There is a reconsideration and appeals process in place, with current standards available to providers who wish to challenge adverse decisions, such as program integrity audit recoveries. This process must assure that appropriate decisions are made as promptly as possible. The chart below illustrates the process to follow when filing a claims reconsideration/resubmission versus an appeal. If the provider has a dispute with the resolution of a claim, they may challenge the claim denial or adjudication by filing an appeal. However, before filing an appeal, the provider should verify the claim does not qualify to be submitted as a claims resubmission or reconsideration.

	Reconsideration	**Appeal**
Form (available online)	Resubmission/reconsideration form	Appeal form
Address	Aetna Better Health of Virginia Attn: Reconsiderations	Aetna Better Health of Virginia PO Box 81040

	PO Box 63518 Phoenix, AZ 85082-3518	5801 Postal Road Cleveland, OH 44181
Appropriate Categories	1) Claim resubmissions 2) Corrected claims (including missing/ incomplete/ invalid diagnosis, procedure, or modifier denials) 3) Timely filing 4) COB (missing/ illegible primary explanation of benefits)	1) Denied days for inpatient stays 2) Authorization denials for late notification 3) Claim denial for no authorization/ preauthorization /medical necessity not met/noncovered charges/benefit exhausted 4) Services denied per finding of a review organization
Timeframe	365 days from the date of service	Claim denial appeals must be submitted within 60 days of the date of denial.

Provider appeal of claim action

Providers may appeal any adverse claim action. Prior to appealing a claim action, providers may contact the CICR department for claims information. In many cases, claim denials are the result of inaccurate filing practices. Please follow the filing practices listed in the above sections as well as the steps below, in order to minimize claims issues:

- Contact the CICR department at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus) as the first step is to clarify any denials or other actions relevant to the claim. A representative will be able to assist a provider with a possible resubmission of a claim with modifications.
- If an issue is not resolved after speaking with Aetna representatives or by submitting a claims resubmission/reconsideration, providers may challenge actions of a claim denial or adjudication by filing a formal appeal with the Aetna Better Health Appeals department.
    - The appeal must be filed in writing and must specifically state the factual and legal basis for the appeal, including a chronology of pertinent events and a statement as to why the provider believes the action by Aetna Better Health was incorrect.
    - Providers must attach copies of any supporting documents, such as claims, remittance advices, medical records, correspondence, etc. If additional copies of medical records are requested for appeal consideration, such copies are created at the provider's expense.
- Appeals should state "formal provider appeal" on the document(s) and should be mailed to:
  Aetna Better Health of Virginia
  PO Box 81040
  5801 Postal Road
  Cleveland, OH 44181

Examples of appeals:

- Denied as not medically necessary
- If a cosmetic denial is upheld and would like it reviewed a second time

Tips to writing an effective appeal

In the event that a provider does not agree with Aetna Health Care of Virginia's decision regarding requested services or benefit coverage, we have provided tips to writing an effective grievance or appeal letter:

- Include the name, address, and phone number where the appealer can be reached in case there are any questions.
- Include the patients name, date of birth, and insurance ID number.
- Describe the service or item being requested.
- Address issues raised in our denial letter.
- Address the medical necessity of the requested service.
- Include information about the patient's medical history:
    - Prior treatments
    - Surgery date
    - Complications
    - Medical condition and diagnosis

If applicable to an appeal situation, please also provide:

- Any unique patient factors that may influence our decision.
- Why alternate methods or treatments are not effective or available.
- The expected outcome and/or functional improvement.
- An explanation of the referral to an out-of-network provider.

When submitting an appeal, be sure to provide the necessary information to describe the patient, treatment, and expected outcomes as described above.

Expedited appeal requests

Expedited requests are available for circumstances when application of the standard Appeal time frames would seriously jeopardize the life or health of the member or the member's ability to attain, maintain, or regain maximum function. A verbal request indicating the need for an expedited review should be made directly to the Prior Authorization department at **800-279-1878** (Medallion and FAMIS), or **855-652-8249** (CCC Plus). Those requests for an expedited review that meet the above criteria will have determinations made within 72 hours or earlier as the member's physical or mental health requires.

Process definitions and determination timeframes

Process	Definition	Determination
Inquiry	Any question from a provider regarding issues such as benefits information, claim status, or eligibility.	Ten working days from receipt of the Inquiry
Grievance	A complaint/grievance is any expression of dissatisfaction expressed by a provider regarding an issue in the health plan. If a provider is dissatisfied with any issue regarding the Health Plan, the provider may contact the respective customer service departments at the number(s) listed above. Complaints/ grievances must be received within 60 calendar days of the date of the incident that gave rise to the complaint.	Within 30 calendar days of receipt of the complaint/grievance
Appeal	An appeal is a request by the provider when the resolution of a complaint or reconsideration is not resolved to the provider's satisfaction and the provider appeals the Health Plan's decision within the prescribed time frames. Examples: a denial or a limited authorization of a requested service, including the type or level of service, that the service is determined to be experimental, investigational, cosmetic, not medically necessary,	72 hours from receipt of the expedited appeal; within 30 calendar days from receipt of the standard appeal request

Process	Definition	Determination
	or inappropriate. The Appeal must be received within sixty calendar days after the date of the health plan's *Notice of Action*.	

Mail written inquires and grievances to:	Mail written appeals to:
Aetna Better Health of Virginia PO Box 81040 5801 Postal Road Cleveland, OH 44181	Aetna Better Health of Virginia PO Box 81040 5801 Postal Road Cleveland, OH 44181

Fraud, Waste and Abuse

Aetna Better Health will not tolerate health care fraud, waste, or abuse in any of its relationships with either internal or external stakeholders. Aetna Better Health will identify, report, monitor, and, when appropriate, refer for prosecution situations in which suspected fraud, waste, or abuse occurs.

Medicaid managed care fraud is defined as the intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some payment or unauthorized benefit to himself and some other person. This includes any act that constitutes fraud under applicable federal or state law.

Medicaid managed care waste is defined as the rendering of unnecessary, redundant, or inappropriate services and medical errors and incorrect claim submissions. Generally not considered criminally negligent actions, Medicaid managed care waste is rather the misuse of resources and involves taxpayers not receiving reasonable value for their money in connection with any government-funded activities due to inappropriate act or omission by players with control over or access to government resources. Waste goes beyond fraud and abuse and most waste does not involve a violation of law; it relates primarily to mismanagement, inappropriate action, and inadequate oversight.

Medicaid managed care abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary costs to the Medicaid Plan, Federal, or State programs.

To report fraud, waste and abuse, contact the Compliance, Fraud, Waste, and Abuse line at **844-317-5825** or submit concerns for fraud, waste, and abuse at **AetnaBetterHealth.com/Virginia/fraud-abuse**.

Aetna Better Health follows a mandatory corporate compliance plan that incorporates annual employee training, system controls, data mining tools, internal auditing, and a designated Special Investigations Unit (SIU) to monitor, detect, investigate, and report potential fraud, waste, and abuse. All Aetna Better Health staff complete required training in identifying potential fraud, waste and abuse and are provided the tools for reporting questionable situations upon hire and annually thereafter. Training includes how to detect and prevent member, provider, and employee fraud, waste, and abuse. Additionally, all customer service staff receives thorough training for fraud, waste, and abuse. Our goal is to operate at the highest level of ethical standards.

The SIU detects and investigates cases of potential health care fraud, waste, and abuse. Examples of fraud and abuse include but are not limited to the following:

- Submitting a claim for services not furnished either by using genuine patient information to fabricate entire claims or by padding claims with charges for procedures or services that did not take place.
- Submitting a claim with inaccurate diagnosis or procedure codes with the intent of maximizing payments or obtaining coverage that the member is not entitled to.
- Submitting a claim knowing reimbursement has previously been remitted.
- Misrepresenting dates of services, description of service, or identity of member or Provider in order to obtain reimbursement to which the provider or member is not entitled.
- Submitting a claim for noncovered services in a manner that categorizes them as covered services.
- Submitting a claim for a more costly service than the one actually performed, commonly known as "upcoding" — i.e., falsely billing for a higher-priced treatment than was actually provided (which often requires the accompanying "inflation" of the patient's diagnosis code to a more serious condition consistent with the false procedure code).
- Submitting unbundled claim(s) for the purpose of avoiding these claim policies and procedures.

The SIU utilizes state-of-the-art data analysis tools to detect irregularities, which could be indicators of possible fraud, waste, and abuse. Clinical investigators and experienced fraud, waste, and abuse investigators work collaboratively to conduct investigations identified through various sources.

The SIU reviews medical claims on a prospective and retrospective basis using sophisticated data mining technology tools to identify and investigate unusual or inappropriate billing patterns. This could lead to some claims being denied for supporting medical documentation. The SIU also may request supporting documentation or schedule an onsite audit to investigate previously paid claims. The investigation does not mean that a provider is practicing fraud. In many cases, the SIU finds the provider billing practice was in error. In all cases, the SIU will work with the appropriate Provider Relations Representative to communicate what is believed an inappropriate billing practice.

If a provider or member is suspected of fraud, waste or abuse, an investigation begins, an audit is performed, and the member or Provider is referred to our Program Integrity Committee for review. When appropriate and an investigation and audit is warranted, those cases are reported to external entities, i.e., including CMS and the Virginia Department of Health and Human Services Office of Inspector General. Reports include the name and ID number of the party involved; the source of the suspected fraud, waste, or abuse; the provider type; nature of the fraud, waste, or abuse; the approximate dollar amount involved; and the legal and administrative status of the case.

If a prepayment or post-payment audit of medical records is indicated to support the paid or submitted claims, Aetna Better Health will utilize our edit guidelines based on but not limited to NCCI, CPT-4, HCPCS, and ICD coding definitions, AMA and CMS guidelines, specialty edits, pharmaceutical recommendations, industry standards medical policy, and literature research input from academic affiliations. If a prepayment or post-payment audit is indicated, the medical record documentation must support the claim.

The HHS-OIG compliance criteria suggest voluntarily conducting an initial, or baseline, audit. Claims self-audits can decrease the risk of enforcement action.

Our credentialing process for contracted providers includes a verification that the provider is eligible to participate. We specifically check the Excluded Provider Database on the HHS OIG website to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid, or SCHIP. This information is also requested on the credentialing and recredentialing application.

Aetna Better Health contract provisions with participating providers specifically state, that they shall not employ or contract for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. The provider hereby certifies that no such excluded person currently is employed by or under contract with them or with any "downstream" entity with which they contract relating to the furnishing of these services to Medicaid members.

Our Credentialing Verification Center conducts ongoing monitoring of the HHS OIG and state professional registration boards internet sites. Any information found pertaining to participating Aetna Better Health providers are referred for review by the credentialing committee to ensure compliance.

Our delegated credentialing entities are required to verify that the providers with whom they contract are eligible to participate, including checking the HHS OIG website to confirm the provider has not been debarred or otherwise sanctioned or excluded by Medicare, Medicaid, or CHIP. Part of our ongoing evaluation of the delegated entities is confirmation of ongoing monitoring of state and federal websites to identify current sanctions or complaints.

As required by the Deficit Reduction Act of 2005, it is Aetna Better Health's policy to provide detailed information to Aetna Better Health employees, vendors or other subcontractors, and other persons acting on behalf of Aetna Better Health, about the Federal False Claims Act, administrative remedies for false claims and statements established under 31 U.S.C 3801 et seq., and applicable State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws (collectively, "False Claims Acts"). The False Claims Acts assist the federal and state government in preventing and detecting fraud, waste, and abuse in Federal health care programs, such as Medicare and Medicaid.